To the Hospital within 24 hours at To the Funeral D

Di State Registrar

29b. Signatur

and title of certifier

32. Registrar's Signature 31. Date filed (Month, Day,

**ORIGINAL** 

290 License number

0006030

29d. Date signed (Month, Day, Year)

and manner stated.

nd address of person who completed vause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25002 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death I. Decedent's Name (First, Middle, Last) Month Physician/ 01251 M thei 07 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis g. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex **Funeral** (Month, Day, Yea 5/4/1916 Days Min 1 🗆 M 2 🖳 217-38-0347 94 Yrs Director Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov amy injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location Maryland Director Annapolis Anne Arundel 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21409 5 Carvel Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: White 3X Widowed 4 ☐ Divorced Completed Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) <u>Elementary School Teacher</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eleanor Rausch ည Christian Rochlitz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Carvel Rd, Annapolis, MD 21409 19a. Informant's Name/Relationship (Type, Print) Paul Betz - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 7/23/2010 Glen Burnie, MD 4 Donation 5 Other (Specify) Atlantic Crematory 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licensee Myclin 147 Duke of Gloucester St. Annapolis Approximate Interval Between 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final ∳nysician/ disease or condition Medical Examiner resulting in death) Due to (or as a con guence of) RACT Infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of ension attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown cate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 📈 No 1 Inpatient 2 ER/Outpatient 3 DOA 잍 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27, Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural iniury 5  $\square$  Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year)

State

Registrar

29b. Signature and title of

30. Nam and address of

TEVEN

Date filed (Month)

erson who completed cause of death (Item 23a) (Type, Print)

2 6 2010

gistrar's Signature

29c. License number

2002 Medical PKWY,

7/22/2010

Annapolis,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25003 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ July Bichner Agnes Mae 2010 21 22:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital 01ney Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, 1 □ M 2 💢 F Months Days Hours Min. 179-30-7939 74 Director Feb. Ĩ936 Pennsylvania Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Md. Montgomery Sandy Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17300 Quaker Lane, D-18 20860 United States within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: White Completed 3 - Widowed 4 - Divorced Year or Dates Page 1 and 2 should be filed within 72 hour: ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natu ury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 0 Administrative Assistant Nursing Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Breech Walter Leiby Martha 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17300 Quaker Lane, D-18, Sandy Spring, Md. 20860 Richard R. Bichner / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Rosemont Cemet. 7/28/2010 Espy, Pennsylvania 21. Si tur of Fin al Service Lice see Name and Address of Eacility, Muriel H. Barber Funeral Home Box 5038, Laytonsville, 20882 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death hock, or heart failure. List only one cause on each line Immediate Cause (Final dis ase or condition resulting in death) ₹hysician/ Due to (or as a consequence of): deys Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): physician and the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 mg 1 Yes 2 Month Pregnant at time of death the detached g 
Unknown Division of Vital Records, P.O. b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 24 hours after death.

Funeral Director: After this certificate beted filled in by the funeral director, page 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 - Homicide determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier The deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29b. Signature and title of certi-

31. Date filed (Month, Day,

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within 2. the

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Physicies

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MATITUR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 | 0 25004 Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2016 M LIFTON OUIS BOWIE 2010 TU Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Howard Community Genera

5. Social Security NumberUKN | 6. Sex <u>Columbia</u> Howard 8. Date of Birth (Month, Day, Year) 3/12/64 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Months Hours 46 Yrs Director MD Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland "natural", or items 23a or 28a-f sho Director 1 Yes 2 No Howard West Friendship 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13754 Old Rover Rd 21794 within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1X Never Married 2 ☐ Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 → No Specify If Yes, Give 3 Widowed 4 Divorced Completed Black Year or Dates Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit, Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Landscaper Landscaping 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Bowie Francis Hackett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha Smith - sister 3826 Old Baltimore Drive, Olney, MD 20832 20a. Method of Disposition Place of Disposition (Name of cemetery crematory or other place 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Park Cemetery 7/24/2010 Cookesville, MD 21. Signatura f Funeral Service Licens 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St., Rockville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure/List only one sause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final sician/ ASCVD disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Pa Base the burial-transit Tause (Disease or impury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ę Month Day Year 5 Other (specify) 4 ☐ Pregnant at time of death 9 ☐ Unknown page 2 should be detached g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 ☐ Yes 2 ☐ No Yes 2 NO 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital Certificate: To 1 Yes 2 **N**O 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury Matural 1 Yes 2 No within 24 hours after death.

To the Funeral Director: Ai completed filled in by the fu Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 | Medical Examiner: On the basis of examination allows introduced at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0069106 16 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GROVE DR. APT. 440 PRAKASH HANOVER, MD 21076 7804

State Registrar 31. Date filed (Month, Day, Year)

2. Registrar's Signature

park

10-05412 Luis Barrios Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 25005
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Cert	tificate of	Death			R	eg. No.		
Physic ledical Exam		1. Decedent's Name (First, Middle,L Luis Fe	elipe Bar	rrios				Date of Dea Month July 20, 2	th Day Yea 010	r	Time of Death 1047 hrs
Þ		4a. Facility Name (if not institution, garden Prince George's Hospital		4	b. City, Town, or Cheverly	Location of	f Death		4c. County of Prince G		
Funera Director		240 40 0000	Sex 7. Age (In yrs. la: <b>X</b> M 2 <b>F</b> 64	st birthday) Yrs.	If Under 1 Year Months Day		r 24Hrs. Min.		/1946	9. Birthpla Foreign Co <b>unt</b>	ace (State or
daryland 28a-f show any d at once.	l io	Usual Residence of Decedent  10a. State 10b. County  MD Prince	e George's La	Town or Location	on					1	d. Inside City Limits Yes 2 X No
ith the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 500 North Hai	#? cry S.Truman I	201 Dr.	10f. Zip Code 20	774		1	ng. Citizen of Wh US		
death w or items	Funer		1 Yes 2 No ed If Yes, Give Year or Dates:	If Ye			Puerto Ri	ican, etc.)	- 14. Race White Specify:		Indian, Black,
11215-0036 Id be filed within 72 hours after fental Hygiene. narked other than "natural", event, the Medical Examiner.	ompleted b	15. Decedent's Education (Specify Elementary/Secondary (0-12)	only highest grade completed)  College (1-4 or 5+)	during mo	's Usual Occupa ost of working life tenanc	DO NOT			16b. Kind of Bu		Managemen
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be Com	17. Father's Name (First, Middle, La Pedro Javier	•						Maiden Surname Melga		
MD 21: d2 should by the and Mer m 27 is mar	2		arrios/daughte	er 200	9 St.T	homa	s Dr	rive #		ldor	E,Md20602
Baltimore, MD 21215-00; permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important. If ities 127 is marked other it mijurg or other traumatic event, the Mage		20a. Method of Disposition  1 X Burial 2 Cremation  4 Danation 5 Other See	Removal from State Ga	rematory or oth	tion (Name of ce er place) Heaver	- 1		0ate 6 / 2 0 1	20c. Location -	•	ring, Md
1		21. (Six) ture of Funeral Service Lice  23a. Part I. Eylier the disease, or con	the second	924	41 Colu	ımbia	Bl	vd.Si		oring	, P.A. , Md20910
Physician Medical Examiner		failure List only one cause on							,		letween Onset and Death
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b.  Due to (or as a consequence of)							-	
executed an and al - transit	al Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of)	Ė							
8760, tificate be execut ng physician and as the burial - tra		UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the	AMENDED  23c. If yes, outcome of pregna 1 Live birth		al death 3	Ectopic	pregnanc	у	23d. Date of Month	delivery Day	Year
Box 68' ne death certiff the attending	18	past 12 months?	4 Pregnant at time of dea	th 5 Oth	er (Specify)						(4-11-2)
S, P.O. Unires that the signed by Id be detach	à		s contributing to death but not res	sulting in the ur	nderlying cause (	given in Pa	t I.	1 Yes		Probably	4 Unknown
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit	Completed			-				24a. Was autop perfor 1  Yes	sy p m <u>ed</u> ? d		y findings available letion of cause of
Vital Rechysician: The this certificate director, page	To Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2 🗹 E	ER/Outpatient		Other4			Residence 6	Other:	
Division of Vital ral or Attending Physician. rs after death. all Director: After this certiled in by the funeral director		27. Manner of Death  1 Natural 5 Pending 2 Accident Investige	Jul 20, 2010	28b. Time of In 1005 hrs		ry at Work′ Yes 2 ✔	No Pa	assenger i	now injury occurrent occur	ollision	
Division  To the Hospital or Attentwithin 24 hours after death To the Funeral Director; completely filled in by the		3 Suicide 6 Could not determine 29a. Certifier			t, factory, office b	ouilding, etc		or Town, S	tate)		toute Number, City , Hyattsville, MD
To the Hos within 24 h	Medical	(Check only 1 Certifying Phys	ician: To the best of my knowledge er: On the basis of examination and and manner stated.			n, death occ				ue to the ca	
2	2	Cartala	ory)	20-1	O.C.				July 21, 20		5uj, 10ui j
			stant Medical Examiner		Street, Baltir	more, Mi	21201				
S Regis	State	1111 11/1/1/1/17	62. Registrar's Signature	back	1						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 1 1 0

25006

			For State of Maryland / Department of Health and 1 - State Certificate of Death		reg. No.
			1. Decedent's Name (First, Middle, Last)	2. Date of Dear	th 3. Time of Death
	Physicia /Medic		PAMELA BATEMAN-SALKEY	07	20 2010 3:05 P M
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of De	ath	4c. County of Death
			FORT WASHINGTON HOSPITAL FORT WASHINGTON		PRINCE GEORGES
	Funeral		5. Social Security Number   6. Sex   7. Age (iii yrs. last birthday)   Months   Days   Hours   Mi	n. (Month, Day	
	Director		579-72-2644 54 105	JULY 7,	1956 WASHINGTON, DC
	land ow		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	Mary Inc.	to	MD PRINCE GEORGES FORT WASHINGTON		<b>X</b> Yes 2 □ No
	r 282	Director	10e. Street and Number 10f. Zip Code	1	log. Citizen of What Country?
	th wit	<u>a</u>	1733 FELWOOD STREET 20744	τ	JSA
	ems erms	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc.
5-0036	be filed within 72 hours after death with the Maryland Hygiene.  Hygiene.  d other than "natural", or items 23a or 28a-f show edent, it is likelied Event, it is likelied at	by	1 ☐ Never Married		Specify: BLACK
5	72 hou 'natura	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of w	vorkina	16b. Kind of Business/Industry
7	within 7 iene.  than "r	nple	Elementary/Secondary (0-12) College (1-4or 5+)  ACCOUNTANT	, salaring	OPM
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	be fill	Be	, , , , , , , , , , , , , , , , , , , ,		walden Surrame)
Ĕ	should be nd Ments marked martic ev	우	TOMMTE LEE BATEMAN BERNIC  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or	E QUALLS	er City or Town State Zin Code)
<u> </u>	alth an 27 Is n r traus		CUTHBERT W. SALKEY/HUSBAND 1733 FELWOOD ST., FOR		
อ์	the He		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
ē	Pages tment of tant: If it		11 Burial 21 (Cremation 31 IHemoval from State 1	/31/2010 F	BRENTWOOD, MD
baitimo	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licensee 22. Name and Address of FacilityM		
ă	permi Depa Impo any it	ķ ļ	MAN FROM 4308 SUITLAND ROA	AD SUITLAN	ND, MD 20746
	Physician /Medical Examiner	ner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as care shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	iom	Approximate Interval Between Onset and Death Week Month
68/60,	rificate be executed g physician and as the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last		,
	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death.  Within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use.	hysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
ras, r	quires that in signed b uld be deta	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		obacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown
Hec	: The law re cate has bee page 2 sho	Completed			
VITal	Physician: r this certific ral director, p	Be	examiner?	Death (Check only o	
0	Phys r this ral dii	٠ <u>.</u>	1   Yes 2   No   Hospital: 1   Monpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursin 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		dence 6 ☐ Other (Specify)  now injury occurred
0	ding h. Afte fune	tion	1  Matural 5  Pending (Month, Day, Year) Injury Work? 2  Accident investigation M 1  Yes 2  No		
DIVISION	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (8 City or Tov	Street and Number or Rural Route Number, vn, State)
	To the Hospital or within 24 hours afte to the Funeral Dir. completely filled in I	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and p 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death of and manner stated.	lace, and due to the occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (Month, Day, Year)
	5		A.M. Alleham W) 4604	16	7/21/2010
	50		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		
	(all		AMIR ALIKHANI 11711 LIVINGSTON ROAD FORT WASHINGTON,	MD 20744	
	Sta	ite	31. Date filed (Month Day, Year)  32. Registrar's Signature		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 25007 State RegistrarAmended item#17, WCHD, SU, 7.27 Certificate of Death 10 2. Date of Death 3. Time of Death Physician/ arc 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NICOMICO If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 F Days Hours Min (Month, Day, Year) 218-48.8029 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 Yes 2 No 28a-f 10e. Street and Number 10f. Zip Co e ō 10g. Citizen of What Country? Funeral 2180 filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian Armed Forces Black. White, etc. 1 Never Married 2 Married ō þ 2 **X** No ☐ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than matic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Be ( 17. Father's Name (First, Middle, Last) Daniel Wesley 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ DRENCE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 East Uard 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important; If it any injury or o once. cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) 2010 Signature of Funeral Service Licensee Isabella 22. Name and Address of Facility Salisbury MD 21501 Home mith) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death moulan Amything Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or iinjury physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical death certificate be Box 68760 for use as been signed by the attending should be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 1 Live Birth
4 Pregnant a
9 Unknown in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 Probably 4 Unknown 1 Tes 2 🗌 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 this certificate has al director, page 2 s 1 Tyes 2 🗌 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director; to 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 24 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 💆 Natural work? 1 \( \subseteq \text{Yes} 5 Pending Acciden
Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [ only one) Certifying Nu 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year) 23110

DHMH 17 Rev 7/2009

State

Registrar

HACI HOQ 31. Date filed (Month) EASTEIN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

27

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 1:15 a<sup>M</sup> 2010 July 30 alexander Corte /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Chester River Manor Kent Chestertown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Feb 28 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 3 1928 **Funeral** Days Hours 1 → M 2 □ F 581-40-4050 82 Puerto Rico Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any hijury or other traumatic event, the Medical Examiner must be mutified at once. 1 Yes 2 No Director MD Kent Chestertown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 323 Calvert St. 21620 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □Yes 2 No If Yes, Give 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Puerto Ricanspecify: 1 Yes 2 No White þ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Assembly Lineworker Food Processor 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rumaldo Lafaria Fela Cortez Lopez ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Wilfredo Soler (nephew) 16465 N. Main St. Bridgeville, DE. 19933 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Aaron Chapel Cem. 8/4/10 Rock Hall, MD. Galena Funeral Home of Stephen L Schaech M00510 118 West Cross St. Galena, MD. 21635 Part Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Circhosos years **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be execu Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending physic for use as the b 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy certificate 1 ☐Yes 2 ☐ No 1 ☐Yes 2 ☐No 124 hours after death.
 Euneral Director: After this certific letely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier within 24 hou

To the Fune

completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) July 92Y Physician/ 2010 10:20A M Chananie David Joe1 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Shady Grove Adventist Hospital 8. Date of Birth (Month, Day April 15 9. Birthplace (State or Foreign CT ntry) 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. **Funeral** Hours 1 ፟ M 2 □ F 67 Director Usual Residence of Decedent 10d, Inside City Limits 28a-f shov 10b. County 10c. City, Town or Location Maryland 10a State the Medical Examiner must be notified at Director 1 🙀 Yes 2 🗌 No Montgomery Silver Spring MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with the Funeral items 23a 20906 USA 14510 Homecrest Road #518 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. 5 þ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White "natural" Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Medical permit. Page 1 and 2 should be filed wift Department of Health and Mental Hygier Important: If item 27 is marked other 1 any injury or other traumatic event, the once. Research Administrator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Beatrice "Unknown" Lester Chananie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4428 Windom Place NW, Washington, Terry Levitin/Ex Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Southwest Ranohes, 1 DBurial 2 Cremation 3 Removal from State 7/26/2010 Menorah Gardens Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address Danis,ansky-Goldberg Memorial Chapels 21. Signature of Funeral Service Licenses MCGreenhut 1170 Rockville Pike, Rockville, Maryland 20852 MO1597 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed Cause (Disease or linjury that initiated events and burial-tran resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the 38 attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy 3 ned by the atter in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant a 9 ☐ Unknown 9 Unknown signed by the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed phods 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform page 2 Yes 2 No certificate 1 Yes 2 X No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 🗌 Yes 2 XNo 1 K Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: After (Month, Day, Year) injury work? 1 X Natural 5 Pending To the Hospital or Attendin.

Within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 □ only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 20057124 su ino 7/25/10

State

Bao Truong, MD 9901 Medical Center Dive, Rockville, Maryland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

		1	For State (	of Maryland / De	epartment Certificate	of Health of Deat	n and M <i>h</i>	ental Hygi Re	ene 2010	25010
			negistrar     Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physicia Medic/		Caroline Mae Cerfoy					July 24,	2010	11:35 p <sup>M</sup>
1	Examin		4a. Facility Name (If not institution, give street and n	umber)		wn, or Locatio			4c. County of Dea	
			Holy Cross Hospital  5. Social Security Number 6. Sex	7. Age (In yrs. last birth		ver Spr	er 24 Hrs.	8. Date of Birth	Montgom 9. Bi	rthplace (State or Foreign
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ırylan	works.	_	10a. State 10b. County	10c. City, Town						1 □Yes 2 No
ne Ma	Sa-f.	Director	Maryland Montgomery	Roc	ckville 10f. Zip C	ode.		10	g. Citizen of What C	ountry?
with t	a or	흐	10e. Street and Number 13901 Bauer Drive			20853			USA	
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Maryland of 2 should be file	to nealin and wental rivilent. If item 27 is marked other than "i		19a. Informant's Name/Relationship (Type. Print)  James B. Heinonen/Son	19b. 19	Mailing Address ( 9 <b>12</b> Gain:	Street and Nu sboro F	mber or Rura Road,	il Route Number, Rockvill	City or Town, State, e, MD 208	Sip Code)
ajtimore, mit. Pages 1 ar	item item		20a. Method of Disposition	20b. Place of I	Disposition (Name	e of ner place)	July		20c. Location - City o	r Town, State
Page	ant: M ant: M ury o		1 Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	Norbech	k Memori	al Park	201	o	Olney,	Maryland
	Department of relations of the land injury or of once.		21. Signature of Euneral Service Licensee		22. Name and Franci 500 Uni	Address of Fa s J. Co versity	acility Dllins Blvd	Funeral	Home Inc	ng,MD 20901
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rds	n sign Ild be	d by						1 □ Y€	es 2 No 3	Probably 4 ₩ Unknown
Division of Vital Records, I or Attending Physician: The law requires the	s been si should t	Completed						24a, Was a		autopsy findings available to completion of cause of
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ita jan:	ertifica ctor, p	Be C	25. Was case referred to medical examiner?				Place of Deat	h (Check only on	ie)	
of V	r this certificate har ral director, page 2		1 Yes 2 No Hospital: 1	Inpatient 2 ER/Ou			Nursing Ho		ence 6 Other (S	pecify)
on C	death. <b>:tor</b> : After thi : the funeral (	ioi	1 Natural 5 ☐ Pending (M		Time of 28 njury M	Bc. Injury at Work? 1 □ Yes	2 [] No	28d. Describe no	ow injury occurred	
Vision Attending		licat	2 Accident Investigation 3 Suicide 6 Could not be 28e. Pla	ice of Injury - At home, far				28f. Location (S	treet and Number or	Rural Route Number,
Div	Direct din b	Certification: To	4 Homicide determined	ilding, etc. (Specify)				City or Town	n, State)	
Hospita	within 24 hours after of To the Funeral Direct completely filled in by	Medical C	29a. Certifier  (Check only one)  (Check only one)  (Check only one)	the best of my knowledge e basis of examination an anner stated.	e, death occurred ad/or investigation,	at the time, da , in my opinion	ite and place , death occu	and due to the ored at the time, or	cause(s) and manne date and place, and o	r as stated. due to the cause(s)
o the	omple	Mec	286. Signature and title of certifier	arrier stated.	29c	. License num	ber	- 2	29d. Date signed (Me	onth, Day, Year)
F 1	7°		( Kuil-		DIT	543	70		7/26/2	010
	•		30. Name and address of person who completed c	ause of death (Item 23a)	(Type, Print)					
			Cheryl Aylesworth, M				W., Si	iver Spi	ring, MD 2	.0902
	St Regist	ate rar	31. Date filed (Month, Day, Year) 32	Registrar's Signature	parles					

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	1- For State Registrar		Certifica	ate of L	Death			Re	g. No.		
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/ledical Examine	Difficia Su	yapa Carbajal	ia Suya <sub>l</sub>	pa Ca	rbajal		Ji	uly 31, 20	010		1047 hrs
	4a. Facilify Name (if not institut	ion, give street and number)		4b	. City, Town, or Lo	ocation of Do	eath		4c. County of Prince G		
	Prince George's Hos	·			Cheverly		[-				
Funeral	5. Social Security Number	6. Sex 7. Age	(In yrs. last birt	hday)	If Under 1 Year Months Days	If Under 24 Hours	4Hrs. 8. Min.		h(MM/DD/YYYY	Foreign	
Director	None	1 M 2 X F	35	Yrs.	World S Days	I Hours	IVIII I.	10/08	3/1974	Count	y)Honduras
	Usual Residence of Decedent										
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Maryland 28a-f show any 1.at ouce. ector	10e. Street and Number				10f. Zip Code			1(	g. Citizen of Wh		?
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215-0036 be filed within 72 hours after death with the Maryland mial Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once. Be Completed by Filmeral Director		12. Was Decedent	Ever in U.S.	13. Was	Decedent of Hispa	anic Origin?	( Specif	Yes or No			n Indian, Black,
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fter d		ivorced If Yes, Give Year	Δ] Νο	1 🔀 Y	es 2 No	specify: Ho	ondu:	ras	Specify:	His	panic
5-0036 led within 72 hours after di tygiene. other than "natural", or the Medical Examiner m		ecify only highest grade com			Usual Occupation			done	16b. Kind of Bu	siness/Ind	ustry
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21; be fill ntal H rked ent,		-							Bonilla		
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. n 27 is marked other than umatic event, the Medisa To Re Comple	- I				Address (Street						ip Code)
imore, MD 21215-003 Pages I and 2 should be filed within ment of Health and Mental Hygiene. Itant: If item 27 is marked other the or other traumatic event, the Med To Re Comm	Jose Aristide	s Castro/Husb			uchanan						Charles Charles
Fire files	20a. Method of Disposition  1 VBurial 2 Cremati	n 3 7 Removal from Sta	1	ory or othe	on (Name of ceme r place)	etery,	Da	ite	20c. Location	- City of To	wii, State
Baltimore, permit. Pages I a Department of He Important: If ite	4 Donation 5 Other		Gen		Cemetery			3/10	Hondu		
Baltimo permit. Page Department C Important: injury or ott	21. Signature of Funeral Servi		1 M		me and Address o						
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Physician	23a. Part I. Enter the disease, failure. List only one sus		the death. Do no	ot enter the	mode of dying, s	uch as cardi	iac or res	piratory arre	est, shock, or he	art	Approximate Interval Between Onset and
/Wedical Examiner	Immediate Cause (Final disease	II. ad da	juries								Death
Examine	or condition resulting in death)	Due to (or as a conse	quence of):								
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760, icate be ex physician the burial	IF FEMALE:	23c. If yes, outcon	ne of pregnancy	_					23d. Date of		
x 687 h certific tending			Constitution of the state			Ectopic pr	egnancy		Month	Da	y Year
Box 68 e death certif the attending ed for use as	1 Yes 2 No 9 🗸 U	7	anio or doda.	Ō Othe	er (Specify)						
O. Boon to the death of the death of the attended for Deached for Deached	past 12 months?  1 Yes 2 No 9 V		but not resultin	g in the un	derlying cause giv	ven in Part I.		23e. Did to	bacco use contr	ribute to the	e cause of death?
P.O. es that the igned by oe detac	<u>a</u>							1 Yes	2 No 3	Probab	oly 4 Unknown
ords, Pwrequires to wrequires to seen sign should be contacted.		·					_	24a. Was	an 24b.	Were auto	psy findings available
aw re has be 2 sho	<u> </u>						_		rmed?	prior to cor death?	npletion of cause of
Rec The licate	5							1 Yes	2 No 1	<b>✓</b> Yes	2 No
tal Rections The certificate ector, page	25. Was case referred to medi examiner?					of Death (Ch				7	
f Vid	1 Yes 2 No		nt 2 🗸 ER/O						Residence 6	Other:	
Division of Vital Records, tal or attending Physician: The law requir is after death.  al Director: After this certificate has been is led in by the funeral director, page 2 should be attended in by the funeral director.	27. Manner of Death	28a. Date of Inju (Month, Day,Y	ear)	Time of Inj		at Work? s 2 $[ar{X}]$ No	- 1		now injury occur	ieu	
ttend death ctor:	Pe 2 Accident Inv	ending unk vestigation	ub								ID A District Oils
ivis lor A after Direction by	3 Suicide 6 X Co	uld not be		arm, street	factory, office bu	iilding, etc.	111	1 Location (S	state)	er or Rura	Route Number, City
Spital on neral I	OD ! 4   Homicide	termined (Specify) UT									
Division of Vital Records, P.O. Box 687.  To the Hospital or Attending Physician: The law requires that the death certification within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as the filled in the funeral director, page 2 should be detached for use as the filled in the funeral director.	29a. Certifier 1 Certifying (Check only one) Medical E	Physician: To the best of my caminer: On the basis of exam	y knowledge, de mination and/or	ath occurre	ed at the time, dat on, in my opinion	e and place, death occur	, and due red at the	e to the caus e time, date	e(s) and manne and place, and o	r as stated due to the	cause(s)
To the vithii rough	2 🗸	and manner stated.			29c. License				29d. Date sign		
2-DEND	29b. Signature and title of cert								August 1,		., 50,, . 50,,
1	after &	rasne 4/11X	<del></del>		O.C.N	1.6.			August I,	2010	
	So. Harrie yira address or pers			111 D	nn Ctrast D	altimore	MD 24	201			
	Melissa Brassell, Mi	<ul> <li>Assistant Medical</li> </ul>	⊏xaminer	TITPE	enn Street, Ba	ашпоге, І	ועוט 21.	ZU I			
	te 31. Date filed (Month, Day Yea			backs	-			_			

			For State Registrar	State	or Marylar		artmen <i>tificate</i>			d Mental H	ygiene Reg. No	Z II I II	25012
			1. Decedent's Name (First, Midd	e, Last)	-	^				2. Date of D		Vac-	3. Time of Death
	Physici /Medio		Cardner				ropt	er		July	20	b 2010	2:30 AM
	Examin		4a. Facility Name (If not institutio		imber)		1		Location of De	eath J	40	. County of Dea	th
-410			The Johns Hopkin					more				altimo	
1	Funeral		5. Social Security Number	6. Sex 1 X M 2 □ F	7. Age (In yrs. 83	last birthday) Yrs.	If Under Months	Days	If Under 24 H Hours M	in. (Month, I	Day, Year)		thplace (State or Foreign buntry)
	Director		226-30-2917 Usual Residence of Decedent		0.3					7-17	-192	27   VA	
	yland how		10a, State 10b. County	'	10c. Ci	ity, Town or Lo	cation						10d. Inside City Limits
	a-f sl	cto	VA Accom	ack	НО	rntown	า						1 ☐ Yes 2X No
	death with the Maryland ems 23a or 28a-f show must be notified at	Director	10e. Street and Number				10f. Zip	-Code			10g. Ci	tizen of What Co	ountry?
	23a 23a 1st b	ra E	34059 Hornto	wn Road			233	395			USA	A	
	tems er mu	Funeral	11. Marital Status	Armed F	cedent Ever in U orces?	l.S. 13.1	Was Deced	dent of His	spanic Origin? n, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	0-	14. Race - Ame Black, Whit	
36	s afte	by F	1 ☐ Never Married 2X Mar 3 ☐ Widowed 4 ☐ Divorced	, Il res, G	2 XNo		1 🗌 Yes	2XNo	Specify:			Specify.Bla	
5-0036	hour tural' al Ex			Year or E	Jales.	16a. Dece	dent's Usua	al Occupa	ation		16b k	Kind of Business	
15	in 72 "na" r ledic	Completed		st grade completed		(Give		rk done d	luring most of a	working		5A -	, in addity
2121	with jiene. r than	E	9	College (	1-4 or 5+)	Cafe	eter	ia W	orker			llops I	Island
	e filec al Hyg othe ent,	Be C	17. Father's Name (First, Middle,	Last)					18. Mother's I	Name (First, Midd			
/lar	uld by Aenta Irked tic ev	2	Clarence O.	Cropper					Lotti	e Dicke	rsor	n	
Maryland	and has ma		19a. Informant's Name/Relations	ship (Type. Print)		19b. Mailir	ng Address	S (Street a	and Number o	Rural Route Num	ber, City	or Town, State,	Zip Code)
	and seatth		Dorothy Crop	per/Wif	е	PO I	30x 3	36,	Hornt	own, VA	233	395	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 → Burial 2 ☐ Cremation	3 ☐ Removal from	State 20b.	Place of Dispondentery, crem	sition (Nan natory or o	ne of ther place	9)	Date	20c. L	ocation - City or	Town, State
Ĕ	Pag ment ant: I ury o		4 Donation 5 ☐ Other (S		Tal	bernad	сте в	sapt.	: /	31-2010	Hor	cntown	, VA
3alt	permit. Depart Import any Inj once.		21. Signature of Funeral Service	<del>Licen</del> see	275	Be	2. Name an	d Addres	s of Facility (	917 W.	Isak	oella s	St.
_	<u>~</u> □ = ĕ ŏ		23a. Part 1. Enter the disease, or	Lely	10							MD 218	301
			shock, or heart failure. List	complications that only one cause on a	caused the deat each line.	th. Do not ent	er the mod	le of dying	g, such as card	diac or respiratory	arrest,		Approximate Interval Between
1	Physician	i	Immediate Cause (Final disease or condition	_a Sef	sis								Onset and Death
	/Medical Examiner		resulting in death)	Duè to	(or as a conseq	quence of):							
	77	<u>ا</u>	Sequentially list conditions,		(or as a conseq								
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<b>S</b> Due to	(or as a conseq	querice oi).							
	and al-trai	Exa	that initiated events ** resulting in death) Last	c	(or as a conseq	quence of):							
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edical		d									
687	ficate physas the			u.									
	death certific attending p		IF FEMALE: 23b. Was decedent pregnant		tcome of pregna							23d. Date of de	livery
Box	that the death cert d by the attending detached for use	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Preg	birth 2 Teta nant at time of d		] Ectopic p ] Other <i>(</i> s <i>p</i>				_	Month	Day Year
P.O.	at the d by the etachec	Å.	9 Unknown	9 🗌 Unk									
	ined i	by	Part II. Other significant condition	ons contributing to	death but not res	sulting in the u	ınderlying	cause giv	en in Part I.	23e. Did	I tobacco	use contribute t	o the cause of death?
Records,	w requires tha been signed should be de	ted					-			1 _	Yes 2	2 Mo 3 □ Pi	robably 4 Unknown
ecc	law request been 2 shou	ed								24a. Was	DDSV	24b. Were a	utopsy findings available completion of cause of
	siclan: The law certificate has t irector, page 2:	Completed								per 1 \sum Yes	formed?	death?	_/
/ita	ysiclan: s certifica director,		25. Was case referred to medical examiner?							eath (Check only	one)		
of Vital	10 D	2	1 ☐ Yes 2 ☑ No			ER/Outpatien			4 🗆 Nursing	Home 5 Res		6 Other (Spe	cify)
		<b>=</b>	27. Manner of Death 1 ☑ Natural 5 ☐ Pendir		of Injury oth, Day Year)	28b. Time of Injury		8c. Injury Work	?	28d. Describe	how inju	ry occurred	
	<b>=</b> . ≠ . □	.0		gation		omo farm etre	M		es 2 No	20f Legation	/Stroot o	nd Number or F	turn Double March of
S	ttendin death. tor: Aft	icatio	2 Accident investigned investigation investigati	not be 280 Place	of injury . At he								
Division	or Attenc	ertificatio	= / looldone	inad Loc. I lace	e of injury - At ho ling, etc. (Specif		et, ractory,	onice			wn, State		ural Route Number,
Divisi	or Attenc	al Certification:	3 Suicide 6 Could determ  4 Homicide 1 Certifyir	build	ling, etc. (Specify	y) wledge, death	occurred	_ at the tim	e, date and pla	City or To	wn, State	and manner a	s stated.
Divisi	or Attenc	dical Certificatio	3 Suicide 6 Could determ  4 Homicide 1 Certifyir	build  g Physician: To the Examiner: On the b	ling, etc. (Specify	y) wledge, death	occurred	_ at the tim	e, date and pla	City or To	wn, State	and manner a	s stated.
Divisi	or Attenc	edical	3 Suicide 4 Homicide  6 Could determ  29a. Certifier (check only 2 Medical	ng Physician: To the Examiner: On the tand man	ling, etc. (Specification) be best of my knowasis of examina	y) wledge, death	occurred a	_ at the tim	oinion, death o	City or To	e cause(se, date ar	and manner a	s stated. le to the cause(s)
Divisi	or Attenc	edical	3 Suicide 4 Homicide  6 Could determ  29a. Certifier (check only one)  1 Certifyir 2 Medical	ng Physician: To the Examiner: On the tand man	ling, etc. (Specification) be best of my knowasis of examina	y) wledge, death	occurred a	at the time in my op License	oinion, death o	City or To	e cause(se, date ar	s) and manner and place, and dute signed (Mont	s stated. se to the cause(s)
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Divisi	or Attenc	Medical	3 Suicide 4 Homicide  6 Could determ  29a. Certifier (check only one)  1 Certifyir 2 Medical  29b. Signature and title of certifie	ng Physician: To the Examiner: On the band main	ling, etc. (Specifi be best of my kno pasis of examina oner stated.	wledge, death tition and/or inv m 23a) (Type,	occurred vestigation,	at the tim, in my op.	number	City or To	e cause(se, date ar 29d. Da	s) and manner and place, and dute signed (Mont	s stated. le to the cause(s)  h, Day, Year)

0-05267		Ple		oe or Print in							egible	e.	
farcus Dewell [			St	ate of Maryla	•				/lental H	ygiene		2010	25013
		1- For State Registrar			Ce	rtifica	ite of Dea	th			Reg. No.		20010
Physici	an/	1. Decedent's Nam				-				2. Date of De Month	Day	Year	3. Time of Death 0125 hrs
Medical Exami	ner √				ah arl		Tab Ciby	Town, or Loca	ation of Dogsth	July 14,		c. County of Deat	
		3308 Rando		n, give street and nur	nber)			eaton	ation of Death			Montgomery	1
Euporal		5. Social Security N	•	6. Sex	7. Age (In yrs. I	last birth			Under 24Hrs	. 8. Date of E			thplace (State or Foreign
Funeral Director		212-02-84		1XM 2F	27	idot bii ti	Mon		Hours Min.		•	Co	ountry)
		Usual Residence o		16 M 2 F			Yrs.			08/2	2/ T2	702	
any		10a. State	10b. County		10c. City	, Town o	or Location						10d. Inside City Limits
<b>*</b> .	Ļ	MD	Montgo	merv	Sil	ver	Spring						1 X Yes 2 No
faryla 18a-f: aton	Director	10e. Street and Nu						ip Code			10g. Cit	izen of What Cou	ntry?
0036 within 72 hours after death with the Maryland join. her than "natural", or items 23a or 28a-f she Medical Examiner must be notified at once	ä	3068 Bel	Pre Ro	oad			20	0906			US	SA	
with ms 23	a	11. Marital Status			dent Ever in U	.S.	13. Was Deced				10-		ican Indian, Black,
death or ite	Funeral	1 X Never Marri	ed 2 M	amied Armed For	2 X No		if Yes, spec	cify Cuban, Mex	xican, Puerto	Rican, etc.)		White, etc.	
after	by F	3 Widowed		orced If Yes, Give Year or Dates:				2∑ No spe					lack
hours natur	eq			cify only highest grade			ecedent's Usua uring most of w				16b.	Kind of Business	Industry
36 iin 72 han '	ble	Elementary/Second	ondary (U-12)	College (1-	4 or 5+)	Rat	rber					Barber	
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	Completed	17. Father's Name	(First, Middle	Last)		Da	LDEL	18.Mc	lother's Name	(First, Middle			
21215-0036 sold be filed within 7 Mental Hygiene. marked other than	Be		•	n McDonald	Jr.				nelby D	•		,	
2121 ould be fil I Mental F I marked ic event, f		19a. Informant's Na				19b	. Mailing Addres				umber, C	City or Town, State	e, Zip Code)
MD id 2 sho lith and m 27 is		Shelby Du		- mother								n, DC 200	
		20a. Method of Dis		ı 3 Remoyel ≸ro			Disposition (Na ry or other place		ry.	Date	20c.	Location - City or	Town, State
Page nent o		4 Donation 5	Other S			ite o	of Heave	en Cem.	7/2	4/10	Si	lver Sp	ring, MD
Baltimore, permit. Pages I as Department of He Important: If ite injury or other tr	- 1	21. Sture of Fu	neral Service	Licen e	1		22. Name an	d Address of Fa				eral Home	
		Den	-	Jane	ich							lle, MD	
Physician Medical		failure. List on			//		enter the mode	or dying, such	as cardiac o	r respiratory a	rrest, sn	ock, or neart	Approximate Interval Between Onset and
Examiner	1	Immediate Cause ( or condition resulting		a. Multiple Gur									Death
	- 1			b.	consequence o	,,,,							
	힐	Sequentially list co if any, leading to in causa. Enter Under	nmediate	Due to (or as a	consequence o	of):							
h 1	Examiner	(Disease or injury t events resulting in	hat initiated	c. Due to (or as a	consequence o	if):							
executed in and il - transit		events resulting in	death) Last	d.		,							
	dical	UNPENDED	1	AMENDED									
ox 68760, eath certificate be ex attending physician for use as the burial -	8	IF FEMALE: 23b. Was decedent	present in the		utcome of preg	nancy					23	d. Date of deliver	
68 certifi nding ise as	ig.	past 12 months		I Live bii	th nt at time of de	2 eath 5	Fetal death		ctopic pregna	ncy	- L	Month	Day Year
Box 68760, e death certificate be the attending physic ed for use as the bur	Physician/Medi	1 Yes 2 1	No 9 🗌 Uni	7		5	Other (Sp						
P.O. Es that the cigned by the coefficient of the c		Part II. Other signi	ficant condit	ions contributing to	death but not r	esulting	in the underlyin	g cause given	in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
ires that the signed by	Completed by									1Y	es 2	No 3 Pro	bably 4 Unknown
cords law requi has been 2 should	e e									24a. Wa	s an opsy		utopsy findings available completion of cause of
eco he law ate has	티									peri 1 ✓ Yes	formed?	death?	es 2 No
tal Rectian: The certificate ector, page	Be	25. Was case refer	red to medica					26.Place of De	eath (Check				
Vita hysici	0	examiner? 1 ✓ Yes	2 No	Hospital: 1 In	patient 2	ER/Out	tpatient 3	DOA Other	<sup>er</sup> 4  Nursin	g Home 5	Reside	ence 6 🗸 Othe	r: Scene
Division of Vital Records, tal or Attending Physician: The law requir is after death.  al Director: After this certificate has been seled in by the funeral director, page 2 should the funeral director, page 2 should	Ë	27. Manner of Deat		28a. Date of Jul 14, 20	f Injury Pay Year)	28b. T	ime of Injury	28c. Injury at \		28d. Describe Subject sh		ury occurred	
SiOr ttend death. ctor:	ij	2 Accident	5 Pend Inves	stigation				1 Yes	2 No				
JVIS after Dire	Certification:	3 Suicide		a not be			m, street, factor	y, office buildin		or Town.	State)		ural Route Number, City
ospita hours ineral		4  Homicide  29a. Certifier		(0) 00))	Front side							ad, Wheaton, M	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn.	is	(Check only		nysician: To the best miner:On the basis of	-	-							
To To com	Medical	29b. Signature and		and manner sta				c. License nun				Date signed (Mo	
2	99	11/1	1	11/1	2			O.C.M.E.				y 14, 2010	
		30. Name/and addr	ress of person	who completed cause	of death (Item	23a)							
	ļ			Assistant Med	ical Evami	205	111 Penn S	treet, Baltin	more, MD	21201			
St	ate	31. Date filed	th, Den Mari	nfn 7. Reg	istrar's Signa	ire	ares.						
Regis	rar	JUL	_ ~ 1 6	UTU LENCE	m p.	1							

10-05477 Robert Vincent Donovan Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #State of Margana / Department of Health and Mental Hygiene 20 | 0 250 | 4

		1- For State Registrar		Cert	tificate of	Death			Re	g. No.	. •	2001
Physici	an/	Decedent's Name (First, Middle,L	ast)						Date of Death Month	Day Year		3. Time of Death
ledical Exami	iner	Robert 4a. Facility Name (if not institution,	Vincent	D	onovan	City Taylor	and nonting		July 22, 20	10		1543 hrs
		12632 Black Saddle Lan			14	b. City, Town, o		or Death		4c. County o		
Funeral			Sex 7. Age	(In yrs. las	st birthday)	If Under 1 Ye		er 24Hrs.	3. Date of Birth		-	place (State or Foreign
Director		186–44–7983	X M 2 F	` '		Months Da	_				Cour	ntry)
		186 44 7933 1 Usual Residence of Decedent	A.W 2	57	115.				09/19	/ 1952		PA.
any		10a. State 10b. County	1	IOc. City, T	Town or Location	n					1	0d. Inside City Limits
daryland 28a-f show any 1 at once,	'n	Maryland Montg	omerv	Gai	thersb	urg						1 X Yes 2 No
Aaryla 28a-f 1 at o	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of Wha	at Countr	y?
th the Maryland 23a or 28a-f sho		549 Summit Hall	Road			2087	7			United	Sta	tes
h with	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S		Decedent of H	lispanic Ong				America	ın Indian, Black,
r deat or ite	Fu	1 Never Married 2 Marri	1 Yes 2 2	No				, Fuelto Ric	an, etc.)	winte,	eic.	
s afte rral", niner	ģ		ed If Yes, Give Year or Dates:	Jaka il		Yes 2X N				Specify:	Whi	
2 hour	ompleted	15. Decedent's Education (Specify Elementary/Secondary (0-12)	College (1-4 or 5-		16a. Decedent' during mo	s osual occup st of working lif	fe. DO NOT	use retired	)	16b. Kind of Bus	iness/inc	lustry
336 thin 7. than edical	nple	12		´	Proper	rty Man	agar			Real Es	stati	
5-00 ed wi lygier other	ပ္ပ	17. Father's Name (First, Middle, La	st)		тторе	LLy Han		's Name (Fi	rst, Middle, M	aiden Surname)	cati	<u> </u>
21215-0036 Juld be filed within 72 Mental Hygiene. marked other than 'c event, the Medical	Be	James	Donovan						osephi:		acks	
O 27 hould nd Med is ma	To	19a. Informant's Name/Relationship	(Type, Print )							per, City or Town		
ore, MD 21215-0036 st and 2 should be filed within 72 hours after death with the Maryland of and and Montal Hygiers than "matural", or items 23a or 28a-f she her traumatic event, the Medical Examiner must be notified at once		Joanne Ebbitt/Si	ster	Taok Di	549 Su	mmit Ha	all Ro	oad, (	Gaither	sburg,	MD.	20877
		1 Burial 2 X Cremation	Removal from State		ematory or othe		emetery,	D	ate	20c. Location -	City of 10	own, State
tim Pag ment tant:		4 Donation 5 Other Special		Metr	opolit	an Crem	1.	7/31/	/2010	Alexand	ria,	Virginia
Baltimore permit. Pages 1 Department of 1 Important: If injury or other		21. Signature of Funeral Service Lic	**************************************	/1	22. Na	me and Addres	ss of Facility	DeVol	L Funer	al Home		
Physician		23a. Part I. Enter the disease, or cor	nplications that caused th	ne death. [	Do not enter the	East De	er Pa	rk Dr ardiac or re	., Ga1	thersbui	rg, I	Approximate Interval
/Medical		failure. List only one cause on	each line.				,		-pto-, a	.,	`	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Subarachnoid He Due to (or as a conseq									
		Sequentially list conditions,	b. Ruptured Berry A	neurysr	n							
	Examiner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conseq c. Hypertensive Car			:e						
_ =	хап	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq		_							
ecuted and transit			d									
Records, P.O. Box 68760, The law requires that the death certificate be executed are has been signed by the attending physician and age 2 should be detached for use as the burial - trans	edical	UNPENDED	AMENDED									
3760, ificate be ig physic s the bur	₹.	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome	of pregna		I domin 3	Ectopic	progranancy		23d. Date of d		
Box 68 e death certif the attending ed for use as	icia	past 12 months?	4 Pregnant at til	me of deat	h =	Ideath 3 er (Specify)		pregnancy		Month	Day	y Year
Bo le deat the at	Physician	1 Yes 2 No 9 Unknow	a Clikilowii									
P.O.	by P	Part II. Other significant conditions	<ul> <li>contributing to death t</li> </ul>	out not res	ulting in the un-	derlying cause	given in Pa	rt I.				e cause of death?
S, P.C puires that on signed I					_							oly 4 🗸 Unknown
cords law requir	be								24a. Was ar autopsy	y pr	or to cor	osy findings available npletion of cause of
Rec The licate l	Completed								perform 1 Yes 2		ath? ✔ Yes	2 No
tal Recian: The	Be (	25. Was case referred to medical examiner?	Hospital:				e of Death (	Check only	one)			
f Vi Physical critics	은	1 Yes 2 No 27. Manner of Death	1 Impatient		R/Outpatient					esidence 6	,	cene
Division of Vital Records, as the taw requires after death.  I be to Attending Physician: The law requires after death.  I birector: After this certificate has been seled in by the funeral director, page 2 should the fine that the funeral director.	on:	1 Natural 5 Pending	28a. Date of Injury (Month, Day,Yea	r)	28b. Time of Inj		ury at Work? Yes 2		d. Describe no	w injury occurre	1	
ivisior or Attend after death Director:	cat	2 Accident Investiga	ation	ry - At hom	ne farm street				Location (St	reet and Number	or Pura	Route Number, City
Div the Hospital or hin 24 hours afte the Funeral Dir npletely filled in	Certification:	3 Suicide 6 Could not determine	ot be	, , , , , , , , , , , , , , , , , , , ,	10, 14111, 011 001,	idetery, emee	bullang, cic	. 201	or Town, Sta		or rear	Troute Number, City
Hospital 24 hours Funeral tely fillec		20a Cartifier	ician: To the best of my	knowledge	, death occurre	d at the time, o	date and pla	ce, and due	e to the cause	(s) and manner a	s stated	
DIVI To the Hospital or within 24 hours afte To the Funeral Dir	Medical		er:On the basis of exami and manner stated.									
O To wit	Me	29b. Signalure and title of certifier	A. C. Marinor Stated.			29c. Licen	se number			29d. Date signed	(Month	, Day, Year)
10		( ) and whel	Med)			O.C	.M.E.			July 23, 201	0	
		30. Name and address of person who			3a)							
			stant Medical Exan		111 Penn 9		more, Mi	21201				
St Regist	ate rar	31. Date filed (Month, Day, Year) 20	32. Registrar's	Signature	park	-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month 22/2010 1729 DARIN M. ELLIS Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) MD 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min. 1070271985 Director 220-08-9304 24 Usual Residence of Decedent 10a. State 10b. County 28a-f shov 10d. Inside City Limits 10c. City. Town or Location filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at Director 1 X Yes 2 No MD Montgamery Germantown 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 20874 USA 13107 Cherry Bend Terrace "natural", or items 12. Was Decedent Ever in U.S.
Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ZNo Specify: Specify: Black 3 Widowed 4 Divorced th and Mental Hygiene.
27 is marked other than "natural" 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Entertainment Actor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Ralph Harold Leo Knox Kellie Elaine Ellis permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kellie Elaine Bivens - mother 102 Mississippi St, Vallejo, CA 94590 20a. Method of Disposition 20b. Place of Bisposition (Name of cemetery, crematory or other place) 1 ☐ Burjaf) 2 ☐ Cremation 3 ☐ Remov tion 5 Other (Specify) 7/27/10 remation Svc Hanover, MD re of Funeral Service Lice 22. Name and Address of Facility Snowden Funeral Home Washington St, Rockville, MD 20850 23a. Part 1. Enter the dise ise, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failule. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) a Physician minute Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or de a consequence of): aftending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day certificate has been signed by the irector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2 🗌 No Yes 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 2 🗷 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) mo

Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Angelo Falcone 9901 Medical Center Drive, Rockville, MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) Physician/ Month 2040M Lamar Fellows tugi Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington Washington County Hospital Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ Months June 9, Yar 930 80 Pennsylvania 210-26-6599 **Director** Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director be notified 28a-f 1 ☐ Yes 2 X No Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral must 11934 Robinwood Dr. U.S.A. 21740 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Cement Company Crane Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked ot r other traumatic ever Alta Forrest Edwin Fellows 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elva D. Fellows/Wife 11934 Robinwood Dr., Hagerstown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 a ò 1 X Burial 2 Cremation 3 Removal from State Important: I any injury o Rest Haven Cemetery 8/6/2010 Hagerstown, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Rest Haven Funeral Chapel S. Men 1601 Pennsylvania Ave., Hagerstown, MD 21742 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications and caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease Physician/ disease or condition resulting in death) Lorena day Medical Due to (or as a consequence If) Examiner Sequentially list conditions Physician/Medical Examine if any, leading to immediate Due to (or as a consequence of) attending physician and for use as the bunial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death been signed by the a should be detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, 1 Nes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? Yes 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I **Division of Vital** 25. Was case referred to medical To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Autistan St., Hage

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Registrar

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32. Registrar

		For State of Ma	aryland / Depa <i>Cel</i>	rtificate of I			ene - N2 0   0	25017
Physic	ian	1. Decedent's Name (First, Middle, Last)	_			2. Date of Death Month	Day Year	3. Time of Death
/Medi	cal -	Jacqueline E.  4a. Facility Name (If not institution, give street and number)	Fox	4b. City, Town, o	r Location of Death	July	24, 2010 4c. County of Death	12:15 A. <sup>M</sup>
Exami	ner	Manor Care Chevy Chase		Chevy			Montgome	ery
Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☑ F 7. Ag	e (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	rear)   Cou	place (State or Foreign ntry) 10
land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
Mary a-f sho	tot	Maryland Montgomery	North P	otomac				1 ☐ Yes 2 🔀 No
ith the or 28; se not	Directo	10e. Street and Number		10f. Zip Code		100	g. Citizen of What Cou	
s 23a nust t		11. Marka Status 12. Was Decedent	Ever in U.S. 13.	20878 Was Decedent of F	lispanic Origin? (Spe	cifv Yes or No-	United Sta	
Baltimore, Maryland 21215-0036  Formit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Me. Ical Examiner must be notified at any injury or other traumatic at any once.	by Funeral	11. Marital Status  1	No	If Yes, specify Cuba 1 ☐ Yes 2 X No	lispanic Origin? (Spe an, Mexican, Puerto I Specify:	Rićan, etc.)	Black, White  Specity:  Wh	, etc. ite
21215-0036 d within 72 hours af giene. er than "natural", or the Me heal Exami	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occup	oation during most of working	na 1	6b. Kind of Business/li	
215 iithin 7 ne. nan "n	Completed	Elementary/Secondary (0-12) College (1-4or	o+)		during most of workir d)	.9	Homo	
d 21 filed w Hygiel other til		17. Father's Name (First, Middle, Last)	<u> </u>	ousewife	18. Mother's Name	(First, Middle, Ma	Home (aiden Surname)	
Maryland Id 2 should be file Ith and Mental Hy Ith smarked oth traumatic event	To Be		olderman			Ruth E	mily Mott	er
lary 2 shou and M is mar sumat	-	19a. Informant's Name/Relationship (Type. Print)					City or Town, State, Z	
e, M 1 and 2 Health tem 27 i		James T. Fox/Son	11501	Cherry	Grove Rd.,	North I	Potomac, MI	0. 20878
faltimore, whit. Pages 1 ar apartment of Hea apartment if item in injury or other ore.		20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ Removal from State			!		,	· —
Baltim permit. Pag Department Important: I any injury o		4 □ Donation 5 □ Other (Specify)	Little Lo		ry 7/30/		Lyles, Ti	N
any ir		> Muchand Il	Melen 10	) East De	er Park Di	., Gaitl	hersburg, l	MD. 20877
Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each I Immediate Cause (Final disease or condition resulting in death)	d the death. Do not enine.  HUN s a consequence of):	ter the mode of dyi	ng, such as cardiac o	CHOK	st, 2EA	Approximate Interval Between Onset and Death
es B <sub>1,2</sub>			a consequence of):					
outed id ansit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events c.						
\$8760, icate be executed physician and s the burial-transit	EX	resulting in death) Last Due to (or as	s a consequence of):					
58760, ficate be ex physician s the burial	edical	d						
I Records, P.O. Box 68760,  The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Me		2 Fetal death 3	□Ectopic pregnand □ Other (specify)	су		23d. Date of deli Month	very Day Year
ds, P.	þ	Part II. Other significant conditions contributing to death	out not resulting in the	underlying cause gi	ven in Part I.	23e. Did tob	acco use contribute to	the cause of death?
Vital Records, ictan: The law requires the certificate has been signerector, page 2 should be control of the co	Completed					24a. Was an autopsy perform	y prior to o ned? death?	ntopsy findings available completion of cause of
Vital   Vital   Vician: The certificate rector, pag	Be C	25. Was case referred to medical examiner?			26. Place of Deat			
or V hysic this ce	은	1 Yes 2 No Hospital: 1 Inpat	ient 2 ☐ ER/Outpatie	all SCI DON			nce 6 Other (Spe	cify)
on or Vita ding Physician:  After this certific funeral director,	io ::	27. Manner of Death  1. □ Natural 5 □ Pending (Month, D	jury 28b. Time lay Year) Injury	Wo	uryat ork? ]Yes 2∏No	28a. Describe no	w injury occurred	
Division or Vita after death.  Director: After this certification by the funeral director;	Certification:	3 Suicide 6 Could not be determined 28e. Place of in	njury - At home, farm, s etc. <i>(Specify)</i>			28f. Location (Str City or Town	reet and Number or Ru n, State)	ural Route Number,
Hospita 24 hours Funeral stely fille	edical C	29a. Certifier Certifying Physician: To the bes (Check only one) 2 Medical Examiner: On the basis and manners	of examination and/or	ath occurred at the investigation, in my	time, date and place, opinion, death occur	and due to the ca red at the time, da	ause(s) and manner as ate and place, and due	s stated. e to the cause(s)
To the within 2 To the comple	Me	29b. Signature and title of certifier	am,		se number 5 7/2		9d. Date signed (Mont	
		30. Name and address of person who completed cause of					0050	
		Truong Bao, M.D., 10110 Mo	trar's Signature		cville, Ma	ry⊥and 2	.0850	
S Regis	tate trar	JUL 37 2010	B. Span	N. D.				

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			for State State Registrar	of Maryland / De	epartment of F Certificate of D	lealth and M Death	lental Hygi Re	ene2010	25018
	Physicia		1. Decedent's Name (First, Middle, Last)  John D.	Fo	rehand Jr		2. Date of Death Month July	21 <sup>Pay</sup> 2010 <sup>Year</sup>	3. Time of Death 2:15 P.M
	Medic Examin		4a. Facility Name (if not institution, give street and n	umber)	4b. City, Town, or	Location of Death	3 027	4c. County of Dea	ath
	Funeral		Prince Georges Hospi  5. Social Security Number   6. Sex	7. Age (In yrs. last birthd	Cheves  ay) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Prince Ge	rthplace (State or Foreign
	Director		104-34-6670 1X M 2 Usual Residence of Decedent	65 Yr	Months Days	Hours Min.	Jan. 6	1945 Nev	V York
	land f show d at	tor	10a. State 10b. County	10c. City, Town o	r Location				10d. Inside City Limits
	r 28a- notifie	Direc	Maryland Prince Georges  10e. Street and Number	Hyat	tsville		10	ng. Citizen of What C	1 X Yes 2 No
	with the s 23a c	<b>Funeral Director</b>	4870 66th. Ave.		2078	30		U.S.A	
<b>.</b>	or item	by Fur	11. Marital Status 12. Was Do Armed	ecedent Ever in U.S. Forces? es 2  No	<ol> <li>Was Decedent of H If Yes, specify Cuba</li> </ol>	n, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
21215-0036	e flied within 72 hours after death with the Maryland tha l-yglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ted b	3 X Widowed 4 □ Divorced If Yes, Year or	Give Dates. 1963–1969	1 Yes 2 No			Specify: B1a	
215-	n 72 ho s. an "nat Medic:	Completed	15. Decedent's Education (Specify only highest grade complet	9d) (G 1/1-4 or 5+)	ecedent's Usual Occup Give kind of work done o Fe. DO NOT use retired)	luring most of workii	ng	6b. Kind of Business	
	filed within tal Hygiene. d other tha event, the N	Be Co		H	ospital Ord	derly  18. Mother's Name			iv. Hospital
/Janc	should be file n and Mental h 7 is marked o raumatic eve	일	17. Father's Name (First, Middle, Last)  John D. Forehand Sr.				nce Cohei		
Maryland	1 and 2 should be of Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print)	15	Mailing Address (Street a				
			Leslie Jones (Daughte	20b. Place of D	hisposition (Name of crematory or other place			20c. Location - City o	
Baltimore,	t. Pag tment rtant: ijury o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal fr. 4 ☐ Donation 5 ☐ Other (Specify)		O Nat'l Cen	netery 7/3		riangle,	
Ba	permir Depar Impor any ir	Ų.	21. Signature Funeral Service Licensee	102		apolis Rd.		n, MD 2070	
			23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause on mmediate Cause (Final	each line.		11	r respiratory arres	t,	Approximate Interval Between Onset and Death
	Physician/ Medical	-	disease or condition	o or as a conseque ce of):	RAIAC A	(RRY Thr	nua		
	Examiner	er	Sequentially list conditions, b.	DIABLE 49	,				
	uted Id ansit	Examiner	ii any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events C.	to (cir as a consequence oi).					
_	cate be executed physician and s the burial-transit			to (or as a consequence of):	:				
8760	ificate b ng phys as the l	Medical	IF FEMALE:						
Box 68	ath cert attendir for use	Physician/M	23b. Was decedent pregnant in the past 12 months?	outcome of pregnancy ve Birth 2  Fetal death regnant at time of death	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	ру	_	23d. Date of d Month	elivery Day Year
0.8	t the de by the stached	Physi	9 Unknown 9 U	nknown		ren in Deut I			
Division of Vital Records, P.O.	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi	by	Part II. Other significant conditions contributing t	o death but not resulting in t	rne underlying cause giv	ven in Part I.			to the cause of death?  Probably 4   Unknown
cord	aw requ as been 2 shou	Completed					24a. Was an autopsy	/ prior to	utopsy findings available completion of cause of
æ	sician: The law certificate has t lirector, page 2 s		25. Was case referred to medical		ne pi	and of Dooth (Charle	1  Yes 2		es 2 🗆 No
Vita	nysiciar nis certi I directo	To Be	examiner?	☐ Inpatient 2 🔀 ER/Outp	104	ace of Death (Checker: 4  Nursing Ho		nce 6 Other (Spe	ecify)
n of	ding Pl th. After th funera			ate of injury Ionth, Day, Year) 28b. Tim inju	ry work	y at :? Yes 2 \sum No	28d. Describe hov	v injury occurred	
visio	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director After this certific completed filled in by the funeral director,	Certificate:	3 Suicide 6 Could not be 28e. Pla	ace of Injury - At home, farm ilding, etc. (Specify)			28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,
Δ	spital o	Medical C	29a. Certifier Lactifying Physician: To the	e best of my knowledge, de	ath occured at the time	, date and place, an	d due to the caus	e(s) and manner as s	tated.
	the Hothin 24 the Fu	Med	(Check 2 Medical Examiner: On the only one) 3 Certifying Nurse Praction  29b. Signature and fitte of certifier	basis of examination and/or in er: To the best of my knowled	nvestigation, in my opinion dge, death occurred at the 29c. License	e time, date and plac	e, and due to the o	I place, and due to the cause(s) and manner and Date signed (Mon	s stated.
	5		250. Signature of Certaine	8/10		3688		July 2	2,2010
	21		30. Name and address of person who completed of	11 1	De Char	Parlas IM	N 20	785	
	Sta		Griffin L Davis 3001 31. Date filed (Month, Day, Year) 32	Registrar's Signature	v. I	111	1) 20	• 00	
	Registra	ar	JUL 2 8 2010 Lener	P. P. PERCE					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25019 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AUGUST Physician/ **EDMUND** RICHARD GUIDO 2010 11:47₽<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHARLES 4170 DONCASTER DRIVE INDIAN HEAD 8. Date of Birth (Month, Day, Year) FEB 3 19 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1**)∑**MM 2 □ F Months Hours 579-64-2292 62 Director 1948 W. VÍRGINIA Usual Residence of Decedent 28a-f shov 10b. County 10a. State the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director INDIAN HEAD MD CHARLES 1 Tyes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral 23a 4170 DONCASTER DRIVE 20640 U. S. A. items hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. Ö 1 Never Married 2 Married Yes 2 K No δ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural", 3 Widowed 4 Divorced Specify: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working should be filed within 72 and Mental Hygiene. within 72 life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4 ENTREPENUER SELF-EMPLOYED Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ ETTORE GUIDO ERMA LOUISE KNIGHT permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEBORAH GUIDO / SPOUSE 4170 DONCASTER DR. INDIAN HEAD, MD 20640 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of **AUGUSET** 20c. Location - City or Town, State Formation 3 ☐ Removal from State TRINITY MEM.GRDN. 5, 2010 WALDORF, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility RAYMOND FUNL.SERVICE, P.A. 5635 WASHINGTON AVE., LA PLATA, MD 20646 Signature of Funeral Service Licensee M00641 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury RUNIT that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burialby Physician/Medical law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 🗌 in the past 12 months? Pregnant at time of death 5 Other (specify) Month Dav Year 1 ☐ Yes ∠ ☐ g ☐ Unknown detached 9 Unknown P.0. s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2/X No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 s autopsy prior to death? To the Hospital or Attending Physician: The I within 24 hours after death.
To the Funeral Director: After this certificate h completed filled in by the funeral director, page perform 1 ☐ Yes 2 ☐ No 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 KResidence 6 Other (Specify) 2 No 1 Yes ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manuner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature a d title of certifier 29c. License number

State Registrar s of person who

32, Registrar's signatu

(Type, Print)

10-05789 Marjorie Anna Griffith Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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		Registrar		ertifica	te oi	Deam				Reg. No.			
Physicia	_	Decedent's Name (First, Middle,Last)							Date of De Month	ath Day	Year	3	B. Time of Death
Medical Examir	ner	Mariorie Anna GR	IFFITH						August 1	, 2010	1001	- 1	1119 hrs
		4a. Facility Name (if not institution, give str Washington County Hospital			4	b. City, Town, or Hagerstown		of Death			ounty of shingt		
<b></b>		5. Social Security Number 6. Sex	7. Age (In y	re last hirth	lav)	If Under 1 Yea		er 24Hrs. 8	B Date of B	irth/MM/DD	ryyyy	9 Birthi	place (State or
Funeral Director				13. 145( 01111	auy)	Months Day		_		· ·	1	Foreign	
Director		219-12-0618 1_M	2XF 97	7	Yrs.		11.00		Marcl	n 1 19	13	Cour	<sup>htry)</sup> Virginia
		Usual Residence of Decedent											
any		10a. State 10b. County	10c. C	City, Town or	r Locatio	on						1	Od. Inside City Limits
E v	_	Maryland Washingto	n l	Boonsl	horo	<b>,</b>							1 X Yes 2 No
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ms 2	eg		. Was Decedent Ever in Armed Forces?	n U.S.		Decedent of His				0- 14	. Race - White,		an Indian, Black,
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ufter	Į P	3 Widowed 4 Divorced If Y	es, Give Year Dates:		1	Yes 2 X No	specify:			Sp	ecify:	V	Vhite
b hours after death with the Maryland "natural", or items 23a or 28a-f show any Examiner must be notified at once.		15. Decedent's Education (Specify only h		) 16a. De	ecedent	's Usual Occupa	tion (Give I	kind of work	done .	16b. Kind	of Busi	ness/Ind	dustry
72 ho	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	- du	iring mo	st of working life	. DO NOT	use retired	)				
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the Wit	팃	17, Father's Name (First, Middle, Last)						's Name (Fi	rst, Middle,	Maiden Su	mame)		
Hille H.	Be (	Peter Simeon Abbott	-			Į.	Marv	Fran	ces F	Ruffne	r		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	밁	19a. Informant's Name/Relationship (Type,		19b	Mailing	Address (Stree	-					State 7	in Code)
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.  tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	-		•		_	,							
MD and 2 sho alith and alith and ran 27 is	ŀ	Lynn H. Griffith -  20a. Method of Disposition				Sharpsbu tion (Name of ce			ate				own, State
F. P.			Removal from State	cremator			illetery,		ale	200. Loc	auon - c	nty Of T	JWII, State
Page:		4 Donation 5 Other Specify:		agers	town	n Cremat	ory	8/4/2	2010	Hag	erst	own	, Maryland
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Deparment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	ŀ	21. Signature of Funeral Service Licensee				ame and Address	-			h Fun	eral	Но	me
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Physician	$\dashv$	23a. Part I. Enter the disease, or complicat	ions that caused the de	ath. Do not	enter the	e mode of dving.	such as c	ardiac or re	spiratory ar	rest, shock,	or hear	iu.	Approximate Interval
\ /Medical	- 1	failure. List only one cause on each li	ne.						,				Between Onset and Death
Examiner	- 1	Immediate Cause (Final disease a. F	lead injuri	es wi	th c	<u>omplica</u>	tions						Death
	- 1	or condition resulting in death)  Due	to (or as a consequence	e of):									
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₩ . E . E	<u> </u>	events resulting in death) Last	10 (0. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0										
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Division of Vital Records, P.O. ral or Attending Physician: The law requires that the safter death.  sa Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	ğ	Part II. Other significant conditions con	itributing to death but no	ot resulting i	n the ur	ideriying cause (	given in Pa	rt I.			-	-	
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ospid hour ner	ပ္မို	4 Homicide  29a. Certifier 1 Certifying Physician:			-				- 4 - 4	(-)			
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	(Check only one) 1 Certifying Physician: 2 Medical Examiner:On	To the best of my know the basis of examination	riedge, deatr on and/or inv	estigation	ed at the time, do on, in my opinion	ate and pia n. death occ	ce, and due curred at th	e to the cau e time, date	and place.	and due	s stated to the o	cause(s)
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	Σ	29b. Signature and title of certifier	// >			29c. Licens		OCHE					n, Day, Year)
		11.1.21	Ky To		,	O.C.	M.E.	OCME		Augus	t 3, 20	10	
	ŀ	30. Name and address of person who comp	oleted Guse of death (I	tem 23a)	-					-L			<del></del>
(h)		Theodore M. King, Jr., MD.	Assistant Medica		er '	111 Penn St	reet, Bal	timore.	MD 2120	1			
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Regist	elf		1 / //										

State of Maryland / Department of Health and Mental Hygiene 2 0 25021 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day HALL **Physician** CHERYL LYNN AUGUST 2:00P M 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 9125 BASSWOOD RUN BEL ALTON CHARLES If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month) Days Hours Min. FEB 18, 1963 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Months 1 □ M 2 12 F MARYLAND 213-84-5602 47 **Director** Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, It a Marileal Expression or use to mother at BEL ALTON Director 1 ☐ Yes 2CXNo MD CHARLES 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? death with 9125 BASSWOOD RUN 20611 S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 3 3 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any injury or other traumatic event, It a Medical Ever resource. 1 ☐ Never Married 2 ☑ Married altimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. Specify: WHITE ş 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 FOOD CLERK GROCERY STORE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOHN STEVEN ROLLINS JR. MARGARET STROBEL ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GARY M. HALL / SPOUSE 9125 BASSWOOD RUN BEL ALTON, MARYLAND 20611 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6, 2010 METRO.CREMATORY ALEXANDRIA, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility RAYMOND FUNL.SERVICE, P.A. 21. Signature of Funeral Service Licen M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause of the conditions of the cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the a d be detached for 1 □Yes 2 □No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ≨ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Conknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Ves 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Lesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Hospital or Attending P 24 hours after death. Funeral Director: After t 28b. Time of 28d. Describe how injury occurred After 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital or within 24 hours at To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 25022 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July Mary Ann Hildebrand ΑM 2010 7:05 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Arnold Anne Arundel 707 Capri Road 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) (OV. 10,1932 Months 1 □ M 2 🛱 F Director 476-30-6202 77 Minnesota Nov. Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo MD Anne Arundel Arnold 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 707 Capri Road 21012 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Was Decedent 2.5.
Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes. Give White 3 Widowed 4 Divorced Specify: Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I is marked o Dana Utton Anna Hult 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Richard Hildebrand / Spouse 707 Capri Road Arnold, MD 21012 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) July 24, 20c. Location - City or Town, State 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, INC. 2010 Baltimore, MD P.A. Severna Park Funeral House Ritchie Hwy, Severna Park, MD 21146 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ance Due to (or as a cubsequence of) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that the death certificate be executed Cause (Disease or imputhat initiated events resulting in death) Last burial-tran Due to (or as a consequence of): physician the burial Physician/Medical Box 68760 ding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) for in the past 12 months? Month Pregnant at time of death ed by the a detached f 2 \( \text{No.} 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Completed Emphy sema 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s Hospital or Attending Physician: The law performed 1 ☐ Yes 2 ☐ No 2 **V**N s after death.

I Director: After this certifica ed in by the funeral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 only one) 1233069 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21401 B3 Petense High way Ste. 109 Amapoles Md. M.B State

DHMH 17 Rev 7/2009

Registrar

		for State of Ma	aryland	l / Depa Cei	artment of F rtificate of E	lealth and N Death	nental Hyg R	iene 20	10	25023
Physicia	n/	1. Decedent's Name (First, Middle, Last)			Date of Death     Month		Year	3. Time of Death		
Medic	al	Robert T. Hemphill, Jr.  4a. Facility Name (if not institution, give street and number)	T., o		July 2			11:00 A M		
Examin	er	16808 Chestnut Street	1	4b. City, Town, or Location of Death  Gaithersburg			4c. County of Death  Montgomery			
Funeral		5. Social Security Number 6. Sex 7. Age	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth		9. Birthp	place (State or Foreign		
Director		328-36-4680	Yrs.	Worth's Days	TIOUIS WIIII.	09/14/14	944	IIIi	try) Lnois	
and show	ا ا	10a. State 10b. County	10c. City,	Town or Lo	cation				1	0d. Inside City Limits
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th the	al D	10e. Street and Number			10f. Zip Code		1	0g. Citizen of V		•
ath wi	Funeral Director	16808 Chestnut Street           11. Marital Status         12. Was Decedent E	ver in U.S.	13.1	20877 Was Decedent of Hi	spanic Origin? (Spe	ecify Yes or No-	United	Stat e - America	
Maryland Z1Z13-UU30 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	ed by F	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced  Armed Forces? 1 ☐ Yes 2 🛣 If Yes, Give Year or Dates.	No		Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2 ሺ No		Rican, etc.)		k, White, e	etc.
72 hou	plet	15. Decedent's Education (Specify only highest grade completed)		(Give	dent's Usual Occupa kind of work done d	ation uring most of work	ing	16b. Kind of Bu	6b. Kind of Business Industry	
rthan rthe M	Completed	Elementary/Seconday (0-12) College (1-4 or 5-	+)		ONOT use retired)  ftware En	nineer		Sc	ience	,
filed w filed w all Hygi tothe vent,	Be	17. Father's Name (First, Middle, Last)		001	Leware III	18. Mother's Name	e (First, Middle, M			
yiand Ild be filed Mental Hy larked oth	욘	Robert T. Hemphill				Georgia	A. Nevi	ins		
Mar 2 shou th and 27 is m traum		19a. Informant's Name/Relationship (Type, Print)			ng Address (Street a					,
I and 3		Lynn Brickman Hemphill (Wif	20b. Pla	ce of Dispo	08 Chestn		Date	20c. Location -		
Page Thent of ant: If in or		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			natory or other place netery	July 20	31,		•	, Illinois
Baltimore, Marylan permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic events.	J	21. Signature of Funeral Service Ligensee  TRACIJASTULAS MO	1117		2. Name and Addres	s of Facility $ { m De} $	Vol Fune			MD. 20877
		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line	the death.	Do not ent	er the mode of dying	, such as cardiac o	or respiratory arres	st,		Approximate Interval Between
Physician	17	Immediate Cause (Final disease or condition Pancreatic Cancer								Onset and Death
Medical Examiner		resulting in death)  Due to (or as a	consequer	nce of):						
lsit A	edical Examiner	Sequentially list conditions, if any, leading to immediate  Cause (Disease or iinjury  Due to (or as a consequence of):								
cate be executed physician and sthe burial-transit	Exa	that initiated events resulting in death) Last C. Due to (or as a	consequer	nce of):					$\top$	
cate be	dica	d								
ertifica ding p		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of	of pregnanc	cy				22d Dat	to of dollars	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trans	Physician/M	1	y 		Mor	te of delive	Day Year			
us, r.O. quires that the signed by und be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown								
The law requires ate has been sig	Completed						24a. Was an autops perform	y p	Were autoporior to condeath?	osy findings available impletion of cause of
VILAI ysician: s certific director,	Be	25. Was case referred to medical examiner?				ce of Death (Check				
ol VI	은	1 ☐ Yes 2 📈 No Hospital: 1 ☐ Inpatie 27. Manner of Death 28a. Date of injur		R/Outpatier 8b. Time of	othe	4 U Nursing Ho	me 5 Reside			
nding ath. :: After	cate	1 Accident Investigation (Month, Day,		injury	work		zod. Describe nov	w injury occurre	u	
al or Attendir s after death. I Director: Af	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injurbuilding, etc.	e, farm, str					t and Number or Rural Route Number, tate)		
he Hospit in 24 hour he Funere	Medical	29a. Certifier 1 Certifying Physician: To the best of r (Check only one) 3 Certifying Nurse Practioner: To the basis of examiner:	amination a	and/or inves	tigation, in my opinio	n, death occurred at	the time, date and	place, and due	to the cau	se(s) and manner stated.
To t To t		29b. Signature and title of certifier  Starza Wille m 0 (5	feren	Wilk	29c. License D 00	63195	29	od. Date signed	(Month, E	Day, Year)
		30. Name and address of person who completed cause of de Dr. Steven Wilks, M.D. 8600	ath (Item 2	3a) (Type, F	Print)		sda, Maı	cyland 2	20814	·
State Registra	_	31. Date filed (Month, Day, Year)  31. Registrar  32. Registrar	's Signatur							

DHMH 17 Rev 1/2001 DCME 2006

State

Registrar

Russell Alexander MD.

31. Date filed (Month, Day Year)

5

111 Penn Street, Baltimore, MD 21201

UUNE

Assistant Medical Examiner

Registrar's Signature

1 - For State Registrar

**Physician** 

/Medical

1. Decedent's Name (First, Middle, Last)

E. Linwood Horseman

4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Homestead Manor Denton Caroline 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Months Min. Hours 1⊠M 2□F 180-14-0077 Director 92 30, 1917 Delaware Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director MD Caroline Denton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Homestead Manor 410 Colonial Drive 21629 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

1s marked other than "natural", or Iter 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify: Specify: 2 3 ☑ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Chesapeake District Elementary/Secondary (0-12) College (1-4or 5+) 9 of Wesleyan Church Minister 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Horseman Louise Wells ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is n any injury or other traun once. P.O. Box 155 Rhodesdale, MD Rev. Paul D. Dieter (Executor) 21659 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Stephens CemeteryJuly 27, 2010 Delmar, Delaware 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Short Funeral Home 21. Signature of Funeral Service Licensee 13 E. Grove Street Delmar, DE 23a. Part Enter the disease, or camplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cardionyo **Physician** dilated /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and burial-trar Due to (or as a consequence of): attending physician Physician/Medical as the IF FEMALE esn 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2□ No 1□ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 1 Yes 2 No 1 Inpatient 3□ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 00053922 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ednum Ave Preston BI Melinda State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

25025

5:01 pM

3. Time of Death

Reg. No.

Dav

2010

2. Date of Death

July 21

Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 25026 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Dea 1. Decedent's Name (First, Middle, Last) Month IDRIS **Physician** MUSTAFA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE HOSPITAL GEORGES GEORGE HEVERI If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, **Funeral** Months Days Hours 1 M 2 □ F 70 579-64-384 02 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f shov any injury or other traumatic event, the Medical Examinar must be notified at COLUMBIA 1 X Yes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA HELEN BORROUG 2001 5000 NANNIE Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No 1 ☐ Yes 2\* If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: CAUCASIAN ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (Q-12) College (1-4or 5+) TRANSPORT DRIVER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 工DRIS ZARIFA MANSY ္ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) NEPHEU FALLS 3400 CHURCH VA -22041 AHMED AL .1. DIEHL Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 Burial 2 Cremation 3 Removal from State 28/10 STAFFORD MAA CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final ARRYTHIMIA CARDIAC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner YPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed ENDSTAGE and burial-trar Due to (or as a consequence of) attending physician Box 68760 Physician/Medical the IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Year 5 Other (specify) signed by the a P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Hospital or Attending 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

e Funeral Director: A pletely filled in by the funeral pletely filled in b death. 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical completely and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and till of certifier

State

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year) JUL 2 8 2010

DPHNELL

ERBATCH M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

8416 CENTRAL AVE. LANDOVER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **JAMESON** ROBERT AUGUSTINE 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Medical Plata Charles La Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Hours 1**X** M 2□ F Days 79 31,1931 MAY MARYLAND 220-16-8951 Usual Residence of 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County 1. Yes 2 □ No MD CHARLES LA PLATA 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 104 THOMAS JEFFERSON STREET 20646 S. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∏Yes 2 □ No If Yes, Give Year or Dates: KOREA 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X XIo Specify: Specify: WHITE ₩Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DEPUTY SHERIFF COUNTY SHERIFF DEPT. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LEON FRANCIS JAMESON MADELINE BAILEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ELIZABETH GARDINER/DAUGHTER P.O.BOX 2004 LA PLATA, MARYLAND 20646 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State MD VETS.CEMETERY 17, 2010 CHELTENHAM, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility RAYMOND FUNL.SERVICE, 21. Signature of Funeral Service Licensee P.A. 5635 WASHINGTON AVE., LA PLATA, M00641 MD 20646 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on ea Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequ IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant condition 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 2 ₽No M 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Medical Center 7C Post

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner P.O. Records, Division of Vital

burial-transi aftending physician for use as the burial signed by the a cate has been si certificate funeral c e Hospital or Attending Pl 124 hours after death. e Funeral Director: After the After e Funeral I completely within 2

**Physician** 

Examiner

**Funeral** 

Director

28a-f show

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or items 23a

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and Mental Hygiene.

Department of Health a Important: If item 27 is any injury or other tra

Pages 1

Director

Funeral

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Completed

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Examiner

Physician/Medical

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Completed

Be

Certification: To

Medical

29a. Certifier

(Check only one)

29b. Signature and title of

Date filed (Month, Day,

traumatic event, the "hydical Examinar" wat by notified at

nours after death with the Marylan

Baltimore, Maryland 21215-0036

/Medical

State

Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 0 25028 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Phyllis Jewell Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany WMHS-RMC Cumberland Birthplace (State or Foreign Country)
 WV If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) Jul 21, 1925 1 □ M 2 □ ₹ Director 219-14-6879 85 Usual Residence of Decedent or items 23a or 28a-f show miner must be notified at 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Cumberland MD Allegany 1 □**x**Yes 2 □ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 411 Pennyslvania Avenue 21502 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify 3 Widowed 4 Divorced white Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) dietician Nursing Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Emma (O'Neil) Davis Norman Lee Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
411 PennysIvania Cumberland MD 21502 19a. Informant's Name/Relationship (Type, Print) Roy Jewell husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Sunset Memorial Park 1 🗷 Burial 2 🗆 Cremation 3 🗖 Removal from State 8/4/2010 MD Cumberland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service 1/2 place 22. Name and Address of Ferility eral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1 Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Di suna Physician, ORMANY disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 21244 Name and address of person who completed cause of death (Item 23a) (Type, Print) 3

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [ ] 25029 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 346A M Physician/ Sabrina Annette Leeper JUI Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Doctor's Community Hospital Lanham If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours Min June 3, 1964 Months Director 46 DC 579-90-0787 Usual Residence of Decedent or 28a-f show s notified at 10a. State 10b. County 10c. City, Town or Location hours after death with the Maryland 10d. Inside City Limits Director Upper Marlboro Maryland Prince George's 1 X Yes 2 No 10e, Street and Number ō 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or limportant: If item 27 is marked other than "natural", or items must be any hiury or other traumatic event, the Medical Examiner must be. Funeral 20774 United States 12412 Cecily Court 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc by 1 Never Married 2 Married African If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Financial Security Analyst Private Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Wilbur U. Edwards Agnes M. Alexis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 20774 12412 Cecily Court Upper Marlboro, Md. Melvin W. Leeper, Jr./ Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State emetery, crematory or other place)
Harmony Memorial 1 🕱 Burial 2 ☐ Cremation 3 ☐ Removal from State 31, ☐ Donation 5 ☐ Other (Specify) Landover, Maryland 21. Sig 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC Part 1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ epsi's disease or condition Medical resulting in death) Examiner Metastah Breast Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ᅌ Pan appenia 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of s certificate has blirector, page 2 s autopsy 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) ၉ 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA : After this funeral of Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending work? of Funeral Director: At bleted filled in by the fu 2 🗆 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 7/12/110 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Groad filed (Month, Day, Year) **JUL 2 8 2010** State 32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 25030 State of Maryland / Department of Health and Mental Hygiene U 1 U For State Registra Certificate of Death Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Physician/ 5.51PM Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town or Location of Death 4c. County of Death Examiner land  $\mathcal{M}_{0}$ If Under 24 Hrs 8 Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** Months Hours Min 1 🗆 M 2 🖾 F Days 6/27/Piv9/54 Vïrginia 213-66-0897 56 Yrs Director Usual Residence of Decedent or 28a-f shov 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland the Medical Examiner must be notified at **Funeral Director** New Carrollton MD Prince George's 1 X Yes 2 ☐ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20784 USA or items 23a 8313 Legation Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: "natural", 3 Widowed 4 X Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic avent." (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Secretary Chandlers Garage Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Edith Marie Thompson Harold Arrington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maggie Park - Niece 15630 Bond Mill Road, Laurel, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Cedar Hill Cemetery 7/31/2010 Covington, Virginia 4 Donation 5 Other (Specify) 4739 Baltimore Ave. 21. Signature of Funeral Service License 22, Name and Address of Facility Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition Medical resulting in death) **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Was deceud... in the past 12 month 1 □ Yes 2 1 No 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy been signed by the atte Month Day Year Pregnant at time of death Unknown 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has autopsy perforn 2 No 1 Yes 25. Was case referred to medical Be B 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Tes ٥ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral Magner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at (Month, Day, Year) Naturai 5 Pending work' 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

10

Registrar

State

31. Date filed (Month, Day, Year)

2 8 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

07, 26, 2010

Battimore, MD 2120

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#20b, perFH, 6906, 8/10/2010, w.S. State of Maryland / Department of Health and Mental Hygiene 2 0 | 0 25031 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Physician/ Month Year 19:00 M 2010 Medical unty of Death 4a. Facility Name (if not institution give street and number, 4b. city, Town, or Location of Death 4c. **Examiner** ndallstown NorthuEST TUSTITE ND MOYE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 KF Min. marulano 2906 Yrs. Director 216-86-Usual Residence of Decedent show 10b. County or than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland **Funeral Director** 1 🗆 Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25422 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homema Homema 0 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Montgomer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Lity or Town, State, ip Code) Miller-BOX416 Sister Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Mt. Nebo Cemetery 7-25-2010 Great Cacapon, WV 4 Donation 5 Other (Specify) 22. Name and Address of acility
Hunter Hnderson Funeral
Hunter Bo Street Der 21. Signature of Funeral Service Lanse 25411 ▶ Ba Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Frd Stage > VEAL disease or condition ) Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Lines Unidenying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. tor. After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? Yes 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 🐪 o Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) That It of pice ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation Director Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled n by determined City or Town, State) within 24 hours a To the Funeral C Medical 1 🌉 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 34053 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M 34 AWathy B/40 21061 bah 01 31. Date filed (Month, Day, Year) 32. Registrar's Si nature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are/Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Charlene Tsabelle Michael Month 3:10 M ZOIC Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Hagerstown Washington Washington County Hospital Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Ap#411, Day, Year 931 WestryVirginia 236-50-1023 79 Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director WV Berkeley Springs Morgan 1 ☐ Yes ※X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 1339 Henry O. Michael Road 25411 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes XX No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 XXNo Specify: Completed 3√Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+ Homemaker Own home 12 traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Dalie Cares Kelley Virginia Lutman Mary permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Virginia Musser - Dtr. 12930 Pectonville Road, Big Pool, MD 21711 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Mt. Pleasant Cemetery 8/3/2010 Berkeley Springs, WV 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Helsley-Johnson Funeral Home, Inc. м00522 95 Union Street, Berkeley Springs, WV 25411 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ betu usouic disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner elmour Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or linjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed lisinc Due to (or as a consequence resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2XXNo Month Day Year the 9 Unknown s been signed by t should be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed? Yes 2 this certificate 2 🗌 No Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 🔼 No ၉ 1 DOA Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🌠 Natural 5 Pending work 1 Tes 2 🗌 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 2 Medical Examiner: On the basis or examination arror investigation, in my opinion, seath occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number D62440

State Registrar 32. Registrar's Signature

Unheran St. Hagestown, MD 21740

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 25033 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Madron Month **July** Debbie 2010 ЗÖ, 1:41 A<sup>M</sup> 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Worcester Atlantic General Hospital Berlin If Under 1 Year 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Days Hours 1 □ M 2 🕱 F 53 1956 Virginia 215-72-2776 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Newark Worcester 1 Yes 2x No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7339 Five Mile Branch Road 21841 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 X Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12 janitor nursing home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lillie Richardson Rankin Ray Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) O. Box 32, Capeville, Virginia 23313 Lillie R. Clark / mother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Occohannock Crematory 8/1/2010 Exmore, Virginia of Funeral ervice Licensee 119 Pine Street 22. Name and Address of Facility Wilkins-Doughty Funeral Home Cape Charles, VA23310 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death

Physician/ Medical Examiner

Physician/

Medical

Examiner

**Funeral** 

Director

or 28a-f shov notified at

"natural", or items 23a or edical Examiner must be n

permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once.

Director

Funeral

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within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

as the burial-tran attending properties for use as use ed by the a ate has been sign page 2 should be completed filled in by the funeral director, 24 hours fter death. Funeral Director. After

DOB: 10/

Robbie

Madron

Division of Vital

To the Hospital or Attending Physician:

29a. Certifier

(Check

only one)

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MID

John Gille-pie,

Ĥ	disease or condition resulting in death)	a	years
Examiner		Due to (or as a consequence of):  Morbid Obesity	year
	Sequentially list conditions, if you have to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to lor as a consequence of:	GRAS
	that initiated events resulting in death) Last	Due to (or as a consequence of):	1922
edica		Diabetes Type 2	years
by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23d. Date of delivery Month Day Year	
	Part II. Other significant conditions co	obacco use contribute to the cause of death?	
Completed		an 24b. Were autopsy findings available prior to completion of cause of rmed? 2 1 Yes 2 No	
Be (	25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
일	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Resident	dence 6 Other (Specify)
Certificate:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) injury work?  M 1 ☐ Yes 2 ☐ No	ow injury occurred
Certi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Scity or Town)	Street and Number or Rural Route Number, vn, State)

Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DO06 3904

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Registrar

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ľ	Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day 2 Year 2010	3. Time of Death 8:05P M		
-	/Medio		Thomas Joseph McDonough  4a. Facility Name (If not institution, give street and number) 4b.	July	4c. County of Death	1				
d.		•	Laurel Regional Hospital		urel		Prince C			
	Funeral Director		578-30-0502 1™ M 2□ F 84 Yrs. Mc	Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec. 27,	Year) 9. Birth Col. 1925 Vir	place (State or Foreign intry) ginia		
	yland how at		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits							
	ne Mar 8a-f s	by Funeral Director	Maryland Prince George's Bowie					1 X Yes 2 No		
	with the			Of. Zip Code			g. Citizen of What Cou USA	intry?		
-	death		8109 Chestnut Avenue   11. Marital Status   12. Was Decedent Ever in U.S.   13. Was If Yes	20715 Decedent of H	ispanic Origin? (Spe an, Mexican, Puerto F		14. Race - Amer Black, White			
920	be filed within 72 hours after death with the Maryland that Hyglene. d other than "natural", or items 23a or 28a-f show event, it a ff. cfcul Exeminer must be notified at		1 □ Never Married 2 □ Married 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Yes 2 X No	Specify:	ilicari, etc.)	Specify:	ite		
Maryland 21215-0036	72 ho "natur	Completed	15. Decedent's Education 16a. Decedent's (Specify only highest grade completed) (Give kind	's Usual Occup	ation during most of workin	9	6b. Kind of Business/I			
121	within lene. • than '	dwo	Elementary/Secondary (0-12) College (1-4or 5+)  12 College (1-4or 5+)		)		DC Governm	ent		
nd	should be filed bd Mental Hygi marked other imatic event, II	BeC	17. Father's Name (First, Middle, Last)	ZIIIQII	18. Mother's Name		<del></del>			
<u>yla</u>	2 should be and Mental is marked craumatic even	2	Joseph M. McDonough		Rose E.					
Mai	S all			,	and Number or Rura. Avenue Bo		City or Town, State, Z	ip Code)		
Baltimore,	% O		20a. Method of Disposition 20b. Place of Disposition	n (Name of	D		Oc. Location - City or T	own, State		
Ĕ	. Pages tment of l tant; If its jury or o		Marv 1	and	7100	/2010 C	rownsville	, MD		
Bai	permit. Page Department Important; If any injury or once.		21. Signature of Funeral Service Licensee	me'an Abre 00 Anna	<sup>▲ of Facility</sup> Robe polis Roae	ert E. E d Bowie.	rownsville vans Funer MD 20715	al Home		
ı			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter th shock, or heart failure. List only one cause on each line.		1	-		Approximate Interval Between Onset and Death		
Jag.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)							
	Examiner		Due to (or as a consequence of):							
	pe sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  b. Due to (or as a consequence of):							
_E	execution and al-trans	Examiner	Cause (Disease of inful) I that initiated events resulting in death) Last  Due to (or as a consequence of):							
98760	ifficate be executed g physician and as the burial-transit	edical	d							
	certific iding p	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy				22d Date of deli	Mary		
O. Box	w requires that the death certific been signed by the attending I should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1	Month	23d. Date of delivery Month Day Year					
ρ. J.	requires that the neen signed by the	by Pr	Part II. Other significant conditions contributing to death but not resulting in the underl	lying cause give	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?		
ord	require een si ould t					1 ☐ Yes	; 2  No 3  Pro	obably 4 Unknown		
II Kecords,	The lar	Completed				24a. Was an autopsy perform	prior to d	topsy findings available completion of cause of		
Vital	Physician; r this certific ral director,	Be	25. Was case referred to medical examiner?	Oth	26. Place of Death					
0	iding Physician; th. : After this certifica funeral director, p	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injur	4 LI Nursing Hon	ne 5 ∐ Resider 8d. Describe how	ice 6 Other (Spec v injury occurred	cify)		
Sior	endin eath. or: Aft	atio	2 Accident		Yes 2 □No					
Division	al or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, the building, etc. (Specify)	factory, office	2	8f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,		
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After t completely filled in by the funera	ledical (	29a. Certifier  (Check only one)  (Check only on							
	To the comp	Me	29b. Signature and title of sertifler	29c. Licens		29	d. Date signed (Month	ı, Day, Year)		
	A.46		1 a municipal		D55861			2010		
	24/		30. Name and address of person who completed cause of death (Item 23a) (Type, Print Abdul Munim, MD Laurel Regional	Hosp		oo Van	Dusen R MD 2	oaa 0707		
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature  JUL 2 6 2010	N.S						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25035 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 25, Day 2010 Year Physician/ July Tyth 0740 A Timothy Joseph Masick Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Hospice/Casey House Rockville Montgomery Co. If Under 1 Year | If Under 24 Hrs. 8 Date of Birth **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 ■ M 2 □ F Months Days Hours Min Feb. 27, 1946 Trenton, N.J. **Director** 136-40-4419 64 Usual Residence of Decedent 10a. State 10b. County I be filed within 72 hours after death with the Manyland lentral Hygiene. I the Hygiene than "natural", or items 23a or 28a-f shorked other than "natural", or items 23a or 28a-f shorter event, the Medical Examiner must be notified at its event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Damascus Maryland Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A 20872 8801 Damascus Road 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1.076 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Yes 2 No 1970 Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ■ No Specify. 1976 Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Material Handeling Cd. Sales Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ပ it. Page 1 and 2 should be intreed of Health and Menter rant: If item 27 is marked njury or other traumatic e Claire Ceremsak Masick Joeseph NMN Masick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8801 Damascus Road, Damascus, MD 20872 Paulina I. C. Masick/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c, Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otl Date ■ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) July 30,2010 Germantown, Maryland Souls Cemetery 21. Signature of Fundal Service Licenses 22. Name and Address of Facility Molesworth-Williams, P.A., 26401 Ridge Rd., Damascus, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Prostate Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live Bertandon 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Dav ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Atrial Fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ■ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has autopsy performe 1 Yes 2 No Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tyes 2 No 잍 Hospice 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ■ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury Natural 5 Pendina 1 Yes 2 No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Effectifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifig 29d. Date signed (Month, Day, Year) 115108 26, 2010

State Registrar DHMH 17 Rev 7/2009 32. Registrar's Signature

1355 Piccard Drive, Suite 201, Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Diane Ruckert,
31. Date filed (Month, Day, Year)

		_	For State of State of Registrar	Maryland / L	epartm Certifica	ent of Hear ate of Deat	tn and M th		Reg. No.	10	25036	
	Physicia		1. Decedent's Name (First, Middle, Last)  JACK LEROY MILLER					2. Date of Dea	ith	o <sup>Year</sup>	3. Time of Death 06:15 A M	
1	Medic Examin		4a. Facility Name (if not institution, give street and numb	4b. C	o. City, Town, or Location of Death			4c. County of Death				
امد	Funeral			7. Age (In yrs. last birth	Month	der 1 Year I If Ur				9. Birthplace (State or Foreign		
	Director		Usual Residence of Decedent									
	laryland 3a-f sho	ector	10a. State   10b. County   Florida   Palm Beach	10c. City, Town	or Location ntana					1	0d. Inside City Limits 1 ☐ Yes 2 🔀 No	
	vith the N 23a or 28 st be not	Funeral Director	10e. Street and Number 38 Sharon Blvd.		10f.	Zip Code	3462-21	76	10g. Citizen of Uni		try? States	
·0	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fujury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status  1  Never Married 2  Married 12. Was Deceder Armed Ford 1  System 15. Was Deceder Armed Ford 1  System 15. Was Deceder Armed Ford 1  System 15. Was Deceder Armed Ford 1  Married 15. Was Deceder Armed Ford 15. Was Deced	dent Ever in U.S. ces? 2  No 1958-	-	cedent of Hispanio pecify Cuban, Me		cify Yes or No- Rican, etc.)		ce - Americ ck, White, e		
-003	ours afte atural", cal Exar	eted b	3 ☐ Widowed 4 ➡ Divorced If Yes, Give Year or Dat	tes. 1962	1 L Ye	s 2 No Spe	ecify:		Specify 16b. Kind of B	v	Thite	
Maryland 21215-0036	hin 72 he ne. <b>than "na</b> ne Medic	Completed by	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4)	4 or 5+)		work done during use retired)	most of workir	ng	Horse			
nd 2	filed wit tal Hygie d other event, th	Be	17. Father's Name (First, Middle, Last)		railie				Maiden Surnam			
aryla	nould be nd Ment marke	욘	Unknown  19a. Informant's Name/Relationship (Type, Print)	19b.	Mailing Addr	ess (Street and Ni		nown I Route Number	; City or Town, S	ty or Town, State, Zip Code)		
e, Ž	and 2 sh Health a em 27 is ther trai		Cathy Butler / Guardian  20a. Method of Disposition	6 20b. Place of		iffith R		aytonsv Date	ille, M		20882	
Baltimore,	Page 1 ment of ant: If it ury or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from 5 4 ☐ Donation 5 ☐ Other (Specify)	State cemeter	y, crematory o	or other place)	7/24			-	a, Va.	
Balt	permit. Depart Import any inj		21. Signatur, of Fundal Service Licensee	1-00470	22. Name Mu	and Address of F riel H.	Barber	Funera	1 Home	Md.	20882	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.    Immediate Cause (Final									
	Inysician/ Medical Examiner		disease or condition resulting in death)  a. Convestive Heart Failure  Due to (or as a consequence of):									
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last  Acute Renal Failure  Due to lor as a consequence of:  Coronary Artery Disease  Due to (or as a consequence of):									
	ecuted and	Examiner										
209	cate be executed physician and s the burial-transif	edical	Hypertension d									
Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death.  Within £4 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months?  1  Live E 4  Pregn	come of pregnancy Birth 2  Fetal death nant at time of death	3  Ectop	oic pregnancy (specify)				ate of delive	ery Day Year	
P.O.	that the ned by the detache	by Phy	9 Unknown  Part II. Other significant conditions contributing to de		n the underlyi	ng cause given in	Part I.		,		ne cause of death?	
rds,	requires been sign	eted k			1 ☐ Yes 2 💆 No 3 ☐ Probably 4 ☐ Unknown  24a. Was an autopsy findings available prior to completion of cause of							
Records, P.O. Box	sician: The law certificate has b lirector, page 2 s	Completed						autor	rmed?	prior to co death? 1 \(\sum \) Yes		
Vita	ysician: s certific director,	To Be	25. Was case referred to medical examiner?  1 □ Yes 2 ⋈ No  Hospital:	Inpatient 2 - ER/Ou	tpatient 3	Other:	f Death (Check		dence 6 🗆 Oth	ner (Specify	·)	
Division of Vital	ding Phy th. After this funeral o		27. Manner of Death  1 ☑ Natural 5 ☐ Pending (Montile 2 ☐ Accident Investigation				how injury occurred					
IVISIO	or Atter after dea Director: In by the	Certificate:	3 Suicide 6 Could not be	of Injury - At home, far ng, etc. (Specify)	e, farm, street, factory, office 28f. Locatio				n (Street and Number or Rural Route Number, Town, State)			
Ω	Hospital	ledical	29a. Certifier 1 Certifying Physician: To the beautifier (Check 2 Medical Examiner: On the basi	is of examination and/o	r investigation	, in my opinion, dea	ath occurred at	the time, date a	ınd place, and dı	ue to the ca	use(s) and manner stated.	
	within To the comple	Σ	only one) 3 Certifying Murse Practioner: T	To the best of my knowl		29c. License num	ber		29d. Date signe	ed (Month,	Day, Year)	
D			30. Name and address of person who completed cause			>005	9416	1	JULY	23,	2010	
	D+1		VLADIMIR RAKHMANI/ 31. Date filed (Month, Day, Year) 32. Re 11. 26 2010			PRINCE P	HILIP	DR OL	NEY M	nd =	20832	
	Sta Registr		32. He 26 2010	sylstran's signature	B. 4	arked						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra AMEND#2perMD8/3/10, EMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2:24 Moskowitz Ju<sub>1</sub>v 2010 Medical 4c. County of Death
Montgomery 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver Spring Holy Cross Hospital . Social Security Number If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign 7 Age (In vrs. last birthday) **Funeral** (Month, Day, Year, Country)
Maryland Days Hours Min 1 □ M 2 😿 F 86 219-10-9703 Director Sep. Usual Residence of Decedent / Det 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director ems 23a or 28a-f sh r must be notified a 1X Yes 2 No Silver Spring MD Montgomery 10e. Street and Number 10g. Citizen of What Country? USA Funeral 20906 15100 Interlachen Drive Apt. 401 items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Examiner Black, White, etc. 1 Never Married 2 Married Completed by and 2 should be filed within 72 hours after thealth and Mental Hygiene. tem 27 is marked other than "natural", or other traumatic event, the Medical Examir 1 ☐ Yes : If Yes, Give 2 🙀 No Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: White Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname)
Minnie Feldman 17. Father's Name (First, Middle, Last) ည Morris Polansky 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15100 Interlachen Drive Apt 401, Silver Spring, MD Harry Moskowitz / Husband item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 X Burial 2 Cremation 3 Removal from State Judean Memorial Grds 7/26/2010 Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and AdEdward by Sagel Funeral Direction, Inc 21. Signature of Funeral Service Licensee ell Ellermin 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 1 Oncetand Death Immediate Cause (Final Physician/ Bronchoalveolar Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury death certificate be executed use as the burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown Year Pregnant at time of death 2 X No 1 ☐ Yes 2 🗷 9 ☐ Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Pleural Effusion/Infection Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an aw has autopsy performed? Hospital or Attending Physician: The 1 ☐ Yes 2 🛣 No Yes 2X No 26. Place of Death (Check only one) Division of Vital 25. Was case referred to medical Be examiner? 2 🔀 No Hospital: Other: 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 X Natural 2 Accider 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 8 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number completed filled in by determined 24 hours Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the P within 24 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D35996 July 23, 2010

Registrar DHMH 17 Rev 7/2009

State

P.O.

2730 University Blvd #400 Wheaton, Maryland 20902

me and address of person who compreted cause of death (Item 23a) (Type, Print)

Linda M. Burrell,

31. Date filed (Month, Day Year)

MD

Baltimore, Maryland 212	sidilia politicado e para 1 agrael +imaga
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Records, P.O. Box 68760,	The law requires that the death certificate he exe
Division of Vital R	al or Attending Physician: T
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1. Decedent's Name (First, Middle, Last)   Marry   Jean   McKay   Jean   McCounty of Death   July 24, 2010   Year   July 25, 2010   Year   July 26, 2010   Year   July 27, 2010   Year   July 27, 2010   Year   July 27, 2010   Year   July 27, 2010   July 28, 2010   Year   July 27, 2010   July 28, 2010   Year   July 27, 2010   July 28, 2010   July 29, 2010   July 29			For State Registrar					,	Cei	tificate of	Death	1		Reg. N		IU	250	38
4. Follow Free Information on present and number   4. (Day, Tony, or Londino) of Training   4. (Day) of Training	Physicia	an a	1. Decedent's Nan		lle, Last,	)	-						Month		Day	Year	3. Time of De	ath
14000 Blazer Lane    14000 Blazer Lane   1.7. Age for yrs. sur birthoday   1.1. Age for yrs. sur birthoday			Mary	Jean	Mcl	Kay							July	24,	2010		9:29 a	М
Second Security Number   Control	Examin	er			-	street and nu	imber)							4	'			
Spanish   Span	Funeval	0				x	7. Age	(In vrs. last bii	rthdav)		_		8. Date of E	Birth				oreia
Use of the content			,							Months Days	Hours	Min	(Month, I	Dav. Yea	1929	Cou	D.C.	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mindred in the cause of the death of the dea	2 >							in Oit T									10d Incide City	Lincita
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23a. Part I. Einer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause (in each of the cause on each line.)  Parkinson's Disease  Due to (or as a consequence of):  Due to (or as a consequenc	thent or transfer or transfer or significant or sig		4 Donation	5 Other (	Specify)		State	l .	of I	Heaven C	emete	ry	2010				ng, MD	
shock, or heart failure. List only one cause on each line. Impediate Lause (Final Immediate Cause or condition resulting in death)    The purp Heart Condition   Parkinson's Disease	Depar Impor		21. Signaturer of F	Funeral Service	Licens M_	Arec	ula		F1 50	ancis J O Unive	· Coli rsity	lins l Blvd	Funera	al H	ome I ver S	nc. prin	g, MD 20	090
To Start Government of person who completed cause of death (Item 23a) (Type, Print)	Physician /Medical Examiner		shock, or he Immediate Cause disease or conditi resulting in death.  Sequentially list or if any, leading to it cause. Enter Und Cause (Disease of that initiated even.	eart failure. Lise (Final ion )  onditions, mmediate lert, in or injury ts	t only or	Parkii Due to  Due to	nson (or as a d	's Disconsequence	ease of): of):		ring, such a	s cardiac o	rrespiratory	/ arrest,			Approximate Interval Betwe Onset and De	
The State of person who completed cause of death (Item 23a) (Type, Print)  D55258  July 26, 2010	by the attending place of the decision of the attending place of the decision		23b. Was deceded in the past 12 1 Yes 2	2 months?	2	1 ☐ Live 4 ☐ Preg	birth 2 gnant at ti	Fetal death			ncy			_				ar
To Start Government of person who completed cause of death (Item 23a) (Type, Print)	gned b		Part II. Other sign	ificant condit	ions co	ntributing to c	leath but	not resulting i	n the u	nderlying cause g	iven in Part	H.	23e. Die	d tobacc	o use conf	ribute to		
To Start Government of person who completed cause of death (Item 23a) (Type, Print)	een si	ted											10	Yes	2 No	3 ☐ Pro	obably 4 2 Un	know
To Start Government of person who completed cause of death (Item 23a) (Type, Print)	te has by age 2 sh	omple											au pe	topsy rformed	?	prior to c death?	ompletion of cau	
To Start Government of person who completed cause of death (Item 23a) (Type, Print)	rtifica stor, p			erred to medica	al						26. Plac	ce of Death			140	I 🗀 i es	2 🗆 140	
To Start Good D55258 July 26, 2010  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	his ce			CPA <sub>O</sub>	F	Hospital: 1 □	Inpatient	2 ER/O	utpatier	nt 3□DOA	ther: 4 🗆 N	Nursing Hor	me 5□Re	esidence	6 <b>X</b> 301	ghte Spec	r's Home	<b>&gt;</b>
To Start Government of person who completed cause of death (Item 23a) (Type, Print)	ath. r: After t e funera	ation:	1 🙀 Natural	5 Pendi						Wo			28d. Describ	e how ir	njury occur	red		
The State of person who completed cause of death (Item 23a) (Type, Print)	after de: Directo	ertifica				28e. Place build	e of Injury ling, etc.	y - At home, fa (Specify)	arm, str	eet, factory, office		2	28f. Location City or 7	(Street Town, St	and Numb ate)	er or Ru	ral Route Numbe	∍r,
The state of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	n 24 hours he Funeral		(Check only			iner: On the I	basis of e	examination a										
	Z withi	Ž	29b. Signature and	d title of certific	er 5 (	Nile		>							_			
odly wilks, Mb 7750 wisconsin Avenue, #211, bethesda, Mb 20014								consin	Ave	enue, #2	11, Be	ethes	da, ME	20	814			
State Registrar  31. Date filed (Month, Day, Year)  32. Registrar's Signature  4. Agarkan								s Signature	far	Kal								

Alan Charles McMannama

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2010 25039

		1- For State Registrar		Ce	rtificate of	Death				Reg. No	<b>D</b> .		
Physici		1. Decedent's Name (First, Midd	le,Last)						2. Date of De Month		Yea		3. Time of Death
Medical Exami	iner	ALAN	CHARLES	McMANNA	AMA				August 1	Day 1, <b>201</b> 0			1325 hrs
		4a. Facility Name (if not institution 6708 Darby Road	on, give street and n	umber)	4	lb. City, Town		n of Death			c. County of Prince G		
Superal		5. Social Security Number	6. Sex	7. Age (In yrs.	last hirthday)	If Under 1		nder 24Hrs.	8 Date of I				thplace (State or
Funeral Director							Days Hou					Foreig	n
		219-90-6990	1 X M 2 F	4.	5 Yrs.				AUG.	23,	1964	Col	"MARYLAND
<b>b</b>		Usual Residence of Decedent  10a. State  10b. County	<del>- ·</del>	10c City	, Town or Locati	00							10d. Inside City Limits
				Too. Oity									1 Yes 2 No
Maryland 28a-f show any d at once.	tor		E GEORGES		HYA	TTSVII							
Mary r 28a ed at	Director	10e. Street and Number				10f. Zip Coo	е			10g. Ci	itizen of Wh	at Cour	ntry?
h the	I Di	6708 DARBY	RD.			20	784				U.	S.A	•
D 21215-0036 shouts after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shoarie event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status	A	cedent Ever in U		s Decedent of es, specify Cu				10-	14. Race White		can Indian, Black,
r deat	Fun	1 Never Married 2 M	1 Yes	2 📉 No									
s afte	þ		orced If Yes, Give Yes or Dates:			Yes 2 X					Specify:		
hour: natu		15. Decedent's Education (Spe			16a. Decedent during mo	s Usual Occu st of working				16b.	Kind of Bus	siness/li	ndustry
36 in 72 iran "	Completed	Elementary/Secondary (0-12)		1-4 or 5+)		11.							
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filed of Hygins of oth		17. Father's Name (First, Middle,					18.Moth		(First, Middle	, Maider			
21215-0036 with be filed within 7 Mental Hygiene, marked other than c event, the Medica	o Be	CHARLE  19a. Informant's Name/Relations		McMANNAN	√IA 19b. Mailing	Addross (C	and M		AN		PADG		7(a Oada)
	ပ				100						•		
≥ g d d m		TERRI COPPO:	LA/SISTER		4007 J Place of Disposi				Date				/ 8 L Town, State
	Н	1 Burial 2 Cremation	3 Removal fr		crematory or oth		,					,	
Lim Ement Tant:		4 Donation 5 Other Sp		CI	IAMBERS	CREMAT	ORY	8-3	3-2010	R	.IVERD	ALE	, MD.
Baltimore, permit. Pages 1 ar Department of Her Important: If ite		21. Signature of Funeral Service	Licensee	M	22. N	ame and Addi	ess of Facil	RAL E	HOME &	CRE	MATOR	IUM.	.P.A.
1		23a. Part I. Enter the disease, or	muca	MO(	カロタエコー うと	SUL GLE	VELAN	II) AVE	KIN	/ERD	ALE.	MI) .	20/3/
Physician /Madia		failure. List only one cause	on each line.	aused the death	. Do not enter th	e mode or dyi	ng, such as	cardiac or	respiratory a	rrest, sn	lock, or nea	rt	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)				anyl I	ntoxi	catio	n				Death
,		or condition resulting in death)	Due to (or as a	consequence o	f):								
	ᡖ	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence o	f):							_	
	를	cause Enter Underlying Cause (Disease or injury that initiated	C.		.,								ł
si, d	Xar.	events resulting in death) Last	Due to (or as a	consequence o	f):								
ion of Vital Records, P.O. Box 68760, tending Physician: The law requires that the death certificate be executed eath. After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial - transit	n/Medical Examiner	▼ UNPENDED	d	23a,27,	28a-f n	er me	906	8-25-	10 vt				
30, ie be ysiciz	ē	IF FEMALE:						0 25	10 12	Loc	Data of	4 - 15	
8760, tificate bung physic	3	23b. Was decedent pregnant in th		outcome of preg pirth		al death	3 Ector	oic pregnar	псу	23	3d. Date of one of the Month		ay Year
Box 68 e death certi the attendin	Physicia	past 12 months?	4 Pregn	ant at time of de	oth	er (Specify)			•	1			
Bo ne deat the at	h S	1 Yes 2 No 9 Unk	9 Unkno	own									
P.O.		Part II. Other significant conditi	ions contributing to	death but not re	esulting in the ur	nderlying caus	e given in F	Part I.		_		_	he cause of death?
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tal Records. cian: The law requil certificate has been rector, page 2 should	Completed								24a. Was				opsy findings available ompletion of cause of
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ital Fiscian:	å	examiner?	- Hospital:	npatient 2	ER/Outpatient				Home 5	Reside	ence 6 🗸	Other	Scene
1 of Vital Records, ing Physician: The law require After this certificate has been si funeral director, page 2 should b	£	1 Yes 2 No 27. Manner of Death	28a. Date (Month		28b. Time of In		njury at Wo		28d. Describe		_		000110
on C ading th.	Certification:	1 Natural 5 Pend			fd 1:10	·	Yes 2	R No		•	, ,		
	<u>ig</u>	2 Accident Inves	stigation 28e Plac	e of Injury - At he			e building e		unknow 28f Location		and Numbe	r or Rur	al Route Number City
Division as or Attendius after death.  al Director: A led in by the fu	퉤	deter	not be	found			e ballallig, t		or Town,	State)	6708	Darl	al Route Number, City by Road
lospit I hour unera		4 Homicide  29a. Certifier 1 Certifying Pt	- 1				d=t0 00d 0		Hyatts				
Divis To the Hospital or At within 24 hours after of To the Funeral Direc	S	(Check only one) 2 ✓ Medical Exam	nysician: To the bes miner:On the basis	of examination a									
To To con	Medical	29b. Signature and title of certifie	and manner s	tated.			nse numbe						th, Day, Year)
		D- 0	D1	20			C.M.E.				gust 2, 2		
	ļ	1 de la	10K	Un-	20-1						J 1 E		
		<ol> <li>Name and address of person Patricia Aronica-Pollak</li> </ol>		se of death (Item ant Medical E	-	111 Penn	Street P	laltimoro	MD 2120	11			
	لي	75 77			_	-	oueel, B	aiumore	, IVID Z IZ(				
Sta	ate	31. Date filed (Month, Day Year)		gistrar's Signatu	· back								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25040 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year · 201 ADRIENNE MONTGOMERY Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BURTSONVI<u>LL</u>E SANCTUARY AT HOLY CROSS MONTGOMERY Social Security Number 6. Sex If Under 1 Year 7. Age (In yrs. last birthday) **Funeral** If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🔀 F 577-70-4880 Days Hours Min. I OWA 1/13/1926 Director 84 Yrs. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD MONTGOMERY 1 √ Yes 2 □ No BURTONSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3415 GREENCASTLE 20866 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Specify: WHITE If Yes, Give Year or Dates. 1 ☐ Yes 2 🗹 No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual-Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) RETIRED PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 DOROTHY DERMAN EDWARD GLADSTONE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VIVIENNE MOORIN/SISTER SEQUOYA RD LOUISVILLE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1  $\square$  Burial 2 ot M Cremation 3  $\square$  Removal from State CHESAPEAKE CRE 7/22/10 4 Departion 5 Other (Specify) BELTSILLE, 21. Signa je of Funeral Service Lice see 22. Name and Address of Facility CAPTTOL MORTUARY DC 20002 Park 1. Enter the disease or c shock, or heart failure. List or omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ly one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ATHEROSCHEROTI disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) equires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery Month Day After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? ORONARY ARTERU 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ♣ 10 autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: ₽ No 2 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide
Homicide 5 Pendina work? Investigation 1 Yes 2 No Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and use to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion in my opinion. In my opinion, and the place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one

the Hospital or Attending Physician; hin 24 hours after death. completed filled in by the funeral dire tor, within 24 hours a To the Funeral C

> State Registrar

DHMH 17 Rev 7/2009

29b. Signature and title of certifier

ASN BBM

asherin

AKHAM SMITH HIEI 2835 31. Date filed (Month, Day, Year) JUL 2 8 2010

Name and address of person who completed cause of death (Item 23a) (Type, Print)

alle

ani

D 28795

SUITENZ

29d. Date signed (Month, Day, Year)

DALTO MD 21209

Kenneth Leon M			ate of Maryla	and / D		of I	Health and			giene		20	10	2504
Physicia		Registrar  1. Decedent's Name (First, Midd	le,Last)		Oer lineate (	<i></i>	- Calif			2. Date of De				3. Time of Death
Medical Exami		Kenneth Le	on Mason.	Sr.						Month July 25, 2		Year		1158 hrs
		4a. Facility Name (if not institution 9204 Constantine Drivers)		ımber)			. City, Town, or Le Fort Washing		Death			c. County of Prince Ge		's
Funeral		Social Security Number	6. Sex	7. Age (In	yrs. last birthday)	L	If Under 1 Year	If Under	24Hrs.	8. Date of B			9. Birt	hplace (State or
Director		578-64-4394	1 X M 2 F	63	3 Y	rs.	Months Days	Hours	Min.	03/3	0/19	947	Foreigi Cou	unt <b>W</b> ash. D.C
		Usual Residence of Decedent												404 beside Oite Units
ow any		10a. State 10b. County	C		City, Town or Loc									10d. Inside City Limits  1 Yes 2 No
arylanc 8a-f sh at onc	Director	Maryland Prince 10e. Street and Number	ce George:	5 1	Fort Wash		10f. Zip Code			-	10g. Cit	izen of Wha	at Coun	21
th the Maryland 23a or 28a-f sho notified at once.	Dire	9204 Constati	ne Dr.			1	2074	4				U.S.A	A.	
h with ems 23	Funeral	11. Marital Status 1 Never Married 2 M	12. Was Dec				Decedent of Hispa , specify Cuban, I				0-	14. Race - White,		can Indian, Black,
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OO3 withingjene.	E O	17. Father's Name (First, Middle,	Last)	-	Del	17	reryman	3 Mother's	Name (	First, Middle,			юTе	sale Floor
21215-0036 uld be filed within 72 Mental Hygiene. marked other than '	BeC	Charles R. Ma								Ducket		ourname,		
21 lould b d Mer s mar	P	19a. Informant's Name/Relations				-	ddress (Street							Zip Code)
re, MD 2 1 and 2 shou Health and N fitem 27 is n		Kenneth L. Maso	<u> </u>				Woodland		•	Lanham Date	<u>,                                      </u>	2070 Location - 0		Town, State
of H		1 Burial 2 Cremation	3 Removal fr	om State	crematory or hesapeak	other	place) Cremato	rv 7	/28	/2010		eltsvi		
Baltimo permit. Page Department of Important: injury or ott		4 Donation 5 Other Si 21. Signature of Funeral Service	becify: Licensee		22	Nan	me and Address o	of Facility						
Balt permit Depart Impor injury		Juhan	1 Den	dr			.3 Annapo							
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cax 68760, eath certificate be attending physici for use as the bun	/Mec	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes,					7			23	d. Date of d	-	
Box 68760 e death certificate b the attending physi ed for use as the bu	cian	past 12 months?	LITTIVE	irth ant at time			death 3 _ r (Specify)	_Ectopic p	regnan	су		Month	D	ay Year
Boy he death the att	hysi		nown 9 Unkno							Tion Bill	$\perp$			
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ords, F aw requires nas been sign 2 should be	eted							<del></del>		24a. Was				opsy findings available
COr ie law i te has t	Completed								_	auto perfe	ormed?	de	or to c ath? ✓ Ye	ompletion of cause of s 2 No
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Vital Physician:	To B	examiner? 1 ✓ Yes 2 No		npatient 2								ence 6 🗸		Scene
ion of tending Pheath.		27. Manner of Death  1  Natural 5 Pend	28a. Date (Month	of Injury , Day,Year)	28b. Time o	i inju		at Work?		28d. Describe	now in	ury occurre	a	
IVISIOI or Atten after death Director: I in by the	ficat	2 Accident Inves	stigation	e of Injury -	At home, farm, str	eet,	factory, office bui	ilding, etc.	2			and Number	or Ru	ral Route Number, City
Div pital o ours aff	Certification:	4 Homicide deter	mined (Specify)							or Town,	State)			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn		CHOOK ONLY	nysician: To the bes miner:On the basis											
To To To Com	Medical	29b. Signature and title of certifie	and manner s	tated.			29c. License	number			29d.	Date signe	d (Mor	oth, Day, Year)
4		Clust					O.C.M	.E.			Jul	y 26, 201	0	
20	ı	30. Name and address of person Ana Rubio MD. Ass	-			Str	eet, Baltimore	e MD 2	1201		'		-	
S	ate	31. Date filed Wonth Day Year)	sistant Medical I	egistrar's Sig		Ju-		o, IVID Z	,201					
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State of Maryland / Department of Health and Mental Hygiene 2 25042 1 - For State Registrar Certificate of Death Decedent's Name (First Middle 1 ast) 2. Date of Death 3. Time of Death Month 07 Physician/ LUCILLE PATRICIA NATHANIEL 2010 3:15 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death MONTGOMERY CASEY HOUSE ROCKVILLE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Min. 1 □ M 2 XX Hours 08/23/1949 FLORDIA Director Yrs 60 137-44-0146 Usual Residence of Decedent or 28a-f show notified at 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director MD PRINCE GEORGES CAPITOL HEIGHTS YYYes 2 \ No ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be I Funeral 9410 CHESTNUT PARK STREET 20743 IISA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXNo If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 within 72 hours after BLACK 1 ☐ Yes 2 XNo Specify. "natural", Completed 3 Widowed 4 Divorced Specify: Year or Dates the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 9TH HOUSEKEEPING MARRIOTT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ilth and Mental F 27 is marked of r traumatic ever ပ UNKNOWN LENA COLONE permit. Page 1 and 2 sh
Department of Health an
Important: If item 27 is m
any injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EDMOND NATHANIEL/HUSBAND 9410 CHESTNUT PARK ST., CAPITOL HEIGHTS, MD 20743 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) WASHINGTON NATIONAL 07/31/2010 SUITLAND, MD 22. Name and Address of Facility MARSHALL'S FUNERAL HOME 21. Signature of Funeral Service Licensee Nuan 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition SETSIS Medical resulting in death) Due to (or as a consequence of): Examiner PERIPHERAL VASCULAR DISEASE WITH LEFT LEG GANGRENE Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death 1 Yes 2 No Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be CEREBRAL VASCULAR ACCIDENT 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopo, performed? Vas 24 No autopsy death? eral Director: After this certificate I filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 💢 No 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE IPU မြ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Griffying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 07/27/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DIANE RUCKERT 6001 MUNCASTER MILL ROAD ROCKVILLE, MD 20855 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 8 2010 JUL Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25043 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Pape + 0935 M Medical 70 Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Annapolis (ent If Under 1 Year I If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 😾 M 2 □ F 235-46-4235 78 0572171932 New York Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Edgewater 1 🗆 Yes 2 🖺 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 198 Lees Lane 21037 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces? 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give "natural", 3 ☐ Widowed 4 ☐ Divorced Specify: White Year or Dates. 1956-58 other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) School Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be Americo Joseph Papetti Emily Farina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jo Papetti/Wife 198 Lees Lane, Edgewater, Maryland 21037 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite Date ě 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Lakemont Memorial Gardens 07/27/2010 injury o 4 ☐ Donation 5 ☐ Other (Specify) Davidsonville, Maryland 22. Name and Address of Facility George F. Kalas Funeral Home, F.A. 21. Signature 2973 Solomons Island Road, Edgewater, MD 21037 Part 1. Finter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Enysiciani rebro vasc disease or condition ) Medical resulting in death) Examiner 000 105010 Sequentially list conditions if any seasing to immediate cause. Enter Underlying Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ n the past 12 months? Day Pregnant at time of death Year 2 No signed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 Yes 2 No 3 Probably 4 Unknown has been sign e 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page certificate l 1 Yes 2 No Yes 2 No Be 25. Was case referred to medi examiner? 26. Place of Death (Check only one) Hospita 2 14 Other: မြ 1 Yes 1 Impatient 2 -ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manne Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred atural Pending within 24 hours after death.

To the Funeral Director: At completed filled in by the fu 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier HU070482 10+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600

DHMH 17 Rev 7/2009

State Registrar

		For State Registrar		State of Ma	ıryland	/ Depail	rtment of H <i>lificate of L</i>	ealth and Death	Mental Hy	giene Reg. No.		25041
Physicia /Medic		1. Decedent's Nam		Patterson					2. Date of De Month July	Day 22		3. Time of Death 8:00 P M
Examin			eavitree :		e (In yrs. lasi		4b. City, Town, or Severna If Under 1 Year	Park	s. 8. Date of Bi	A	County of Deat	
Director		059-28-1 Usual Residence of 10a. State	of Decedent  10b. County		76 10c. City, 7	Yrs.	Months Days ation	Hours Mir	Nov. 1	6,193	33 Ner	W York  10d. Inside City Limits
ith the Mari or 28a-f sh	Director	MD  10e. Street and Nu			Se	verna	10f. Zip Code			_	izen of What Co	1 □Yes 2 No Duntry?
filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examinar must be notified at	by Funeral	11. Marital Status	eavitree in the control of the contr	12. Was Decedent E Armed Forces? 1  Yes 2 N If Yes, Give Year or Dates:			as Decedent of Hi Yes, specify Cubar		(Specify Yes or No erto Rican, etc.)		JSA  14. Race - Ame Black, White  Specify: W	
permit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any Injury or other traumatic event, Ital Medical Evernionce.	Completed	Elementary/Second		ade completed)  College (1-4or 5-		(Give k life. Di	ent's Usual Occupa ind of work done d O NOT use retired, memaker	luring most of w )			Home	Industry
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permit. Pages Department of Important: If its any Injury or o		4 ☐ Donation	☐ Cremation 3 ☐ 5 ☐ Other (Speciumeral Service Lice		Arun		ition (Name of al National Contest of Contes		gust 25, 2010		lington	r, VA
Physician / /Medical Examiner	Examiner	shock, as he Immediate Cause disease or condition resulting in death)  Sequentially list confirmed to incause. Ener Undo Cause (Disease on that initiated event	on ditions, mediate errying rinjury s	nplications that caused one cause on each lin  a. CO Due to (or as a b. Due to (or as a c.	2577 a consequer	Do not ente	r the mode of dying	g, such as cardi	Sei	rrest,	Park,	MD 21146  Approximate Interval Between Onset and Death M v Office S
The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical Ex	IF FEMALE: 23b. Was deceder in the past 12 1 □ Yes 2 9 □ Unknowr	nt pregnant 2 morths?	Due to (or as a d	of pregnanc 2 □ Fetal de	y eath 3□	Ectopic pregnancy Other (specify)	,			23d. Date of de Month	elivery Day Year
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To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the	Medical Certi	4 ☐ Homicide  29a. Certifier (Check only	1 Certifying P	hysician: To the best of miner: On the basis of	of my knowle				ace, and due to the		s) and manner a	
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DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25046 State
Registra MEND#18, 19aper INF, 7-29-10-HW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death PAULOSE Physician/ Month 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BAUTIMORE UNIVERSITY OF MARYLAND MEDKAL CONTO If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1X M 2 | F 04725754 Kerala Director 219-45-9305 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location? 10d. Inside City Limits Director Rockville Montgomery Md 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20850 Indian 14019 Pellita Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Completed by Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: Asian 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private Maintenance Tech 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) and Mental F ည C.J. Paulose ya Informant's Name/Relationship (Type, Print)
Valsanna, Thengumvila, Joy--wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14019 PELLITA Ter Department of Health Important: If item 27 any injury or other tr Rockville, Md 20850 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Gates of Heaven 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/28/10 Silver Spring, Md 21. Signature of Funeral Service Licensee 'shead <sup>A</sup>ଫ୍ୟୁଲିଆ Home&Cremation Service 5732 Georgia Ave Nw Washington,DC 20011 0777 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ateral disease or condition Medical resulting in death) Examiner cerebrovascu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events sician and burial-transit requires that the death certificate be execute Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Day Pregnant at time of death 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by diabetes mellitus 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed 2 🔀 No Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital 2 🗆 No 2 1 Npatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation

P.O. Records, **Division of Vital** 

To the Hospital or Attending Physician: The I within 24 hours after death.
To the Funeral Director. After this certificate he gompleted filled in by the funeral director, page

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 100541 JUL 24 2010

28f. Location (Street and Number or Rural Route Number, City or Town, State)

A M

Year

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D. KALYON, 22 SOUTH GREENE ST, BALTIMORE MD 21201

Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year)

6 Could not be

determined

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25047 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 20°1°0 11:56 AM Raquel Palmer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 F Hours Months 6/12/1932 Puerto Rico 061-28-0234 78 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 X Yes 2 No MD Montgomery Chevy Chase 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral with 20815 USA 3216 Pauline Drive within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married þ 1 Yes 3altimore, Maryland 21215-0036 1¥ Yes 2 □ No Specify: "natural", 3 Widowed 4 Divorced Completed Year or Dates Puerto Rico <u>Puerto Rican</u> Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Social Worker/Therapist Private Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Juan Sosa Cristina Rivera 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3216 Pauline Drive John H. Palmer/Husband Chevy Chase, MD 20815 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-23-2010 Riverdale,MD Riverdale Park Signature of Funeral Service Licensee 22. Name and Address of Facility Latney's Funeral Home, Inc. Georgia Ave NW Washington, DC cc0278 23a. Part 1. buter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Year Immediate Cause (Final Physician/ Metastatic Bladder Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to miniediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ייי יויס רעוופרמו עודפרנסוי. Atter this certificate has been signed ו completed filled in by the funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by Chronic Kidney Disease División of Vital Records, 1 🗌 Yes 2 🔀 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Yes 212 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ ER/Outpatient 3 DOA 1 🔀 Inpatient 2 🗆 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: the Hospital or Attending 5 Pending 1 🔀 Natural 1 Yes 2 No Accident within 24 hours after death To the Funeral Director: A Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) ပ D67986 7/17/10 ad address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Yuneng Li

31. Date filed (Month, Day, Year)

8600 Old Georgetown Road Bethesda, MD

20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Beatrice E. Porter 8:51 PM 26 July Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Caring Hearts Assisted Living Prince George's Bowie 5. Social Security Number 7. Age (In yrs. last birthday) If Under Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** (Month, Day, 1 □ M 2 🔀 F Months Hours Min 577-03-3294 94 Virginia Director 1916 June Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Prince George's Lanham Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 72 hours after death with 9200 4th Street 20706 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker filed Be permit. Page 1 and 2 should be filed. Department of Health and Mental Hy Important: If item 27 is marked off any injury or other traumatic access. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည (Unav.) Sophie White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alan E. Porter / Son 9200 4th Street, Lanham, MD 20706 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 7/29/2010 Fort Lincoln Cemetery Brentwood, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Hyattsville, MD 20781 Gasch's Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do ot enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Enysician/ BL disease or condition resulting in death) Medical **Examiner** 2 years rance Sequentially list conditions, if any leading to in middle cause. Enter Underlying Cause (Disease or iinjury Examine sician and burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 5 Other (specify) Day Pregnant at time of death signed by the a g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed? Yes 2 No 2 No 1 Tyes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: မ 4 Nursing Home 5 Residence 6 Other (Spec 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred After 1 Natura. 2 Accident 5 Pending nours at er death. neral Director Afi I filled in by the fur 1 🗌 Yes 2 🗌 No Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral C completed filled To the Hospital Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sherene Nasaralak MD 6505 Keni Worth and

Registrar DHMH 17 Rev 7/2009

State

MD

Sherene Nasaralah

31. Date filed (Month, Day, JUL 28

			For State Registrar	State of M	aryland / I	Depa <i>Cert</i>	rtment of tificate of	Health Death	and M		giene Reg. No.	2010	25049	
	Physicia	ın/	1. Decedent's Name (First, Middle, La							2. Date of Dea		Year	3. Time of Death	
	Medic	al	MARGARE  4a. Facility Name (if not institution, giv		DELINE		RANI 4b. City, Town		of Dooth	Aug.		2010	9:00 A M	
_	Examin	er	2041 Nelson		ad.			rrett		lle	46.0	County of Dea Hai	ford	
	Funeral		Social Security Number     6. 9		e (In yrs. last birt		If Under 1 Year Months Day	r If Under		8. Date of Birt		9. Bir	thplace (State or Foreign	
	Director		220-05-2374 Usual Residence of Decedent	I LI M 2 22 F	87	Yrs.	World Day	, riodio		1/14/	1923	5 IV	unity) laryland	
7	and show lat	or	10a. State 10b. County	-	10c. City, Tow	n or Loca	ation						10d. Inside City Limits	
3	Maryii 28a-f otifiec	irect	MD. Ha	rford			Jar	retts	vil.	le			1 ☐ Yes 2🛣 No	
4	3a or	al D	10e. Street and Number				10f. Zip Code				_	en of What Co		
-	ath wi	Funeral Director	2041 Nelson	12. Was Decedent I		13 W	as Decedent of	21084		cify Yes or No-		11 T e C. 4. Race - Ame	States	
)36 )	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Infordant if fire Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces  1  Yes 2   If Yes, Give  Year or Dates.	No No	1	/as Decedent of Yes, specify Cu ☐ Yes 2 【【			Rican, etc.)		Black, Whit		
Ö Q	'natur dical	olete	15. Decedent's	Education	16a	. Decede	ent's Usual Occ	upation	t of worki	20	16b. Kin	d of Business	Industry	
12	Description of the state of the													
Q 2	Hygie Other ent, th	Be	17. Father's Name (First, Middle, Last)				nouse		er's Name	(First, Middle,	Maiden Su	HO:	ine	
/lan	d be ti Vental arked tric ev	욘			Sanders	3		Ma	rgar	et ]	Ethe	l T	ownsley	
Maryland 21215-0036	should and f		19a. Informant's Name/Relationship (										p Code) 21084	
e, N	and 2 Health tem 27 ther to		Margaret A. G: 20a. Method of Disposition	riffith			Box lition (Name of					e, Ma	ryland	
nor	Page 1 ment of 1 tant: If it lury or o		1 ABurial 2 Cremation 3 4 Donation 5 Other (Spec		cemete	ry, cremi	atory or other p		Aug:	)10		-		
Baltimore,	permit. P Departme Importar any injur once.		21. Signature of Funeral/Service Licer		ALL	_	Name and Add						Maryland Funeral	
m i	Depar Impor any ir	D. A	11. Blacker	Turk		I	Home,	ο Α.					arvland	
- (P)	nysician/ Medical	27 F	Part 1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line	э.	LAL	the mode of d	ving, such as	cardiac o	r respiratory an	rest,		Approximate Interval Between Onset and Death	
E	Examiner				a consequence	01).								
9 -	±	iner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence	of):								
(b) §	ate be executed oblysician and the burial-transit	dical Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as	a consequence	ofl-								
	sician burial	cal	· · · · · · · · · · · · · · · · · · ·	■ d	,	,								
3760 Feet 1	incate ig phy as the	Medi	IE EE MALE.	d										
Box 68	The instance of a mentioning right continues that the cash certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome 1  Live Birth 4  Pregnant a 9  Unknown	2 Fetal deat		Ectopic pregna Other (specify)	incy			23	3d. Date of de Month	olivery Day Year	
S, P.O.	signed by	Completed by P	Part II. Other significant conditions  Chronic Obstru		out not resulting			-	l.	23e. Did to			o the cause of death? Probably 4 $\square$ Unknown	
orc	is beer 2 shou	plet				1				24a. Was		24b. Were au	ntopsy findings available completion of cause of	
Rec	s certificate has blirector, page 2 s	Com								perfo	rmed?	death?	s 2 No	
<u>a</u>	certific ector,	Be	25. Was case referred to medical examiner?	Hospital:				Place of Dea	th (Check	only one)				
	h. After this certific funeral director,	e: 10	1 ☐ Yes 2 No 27. Manner of Death	1 Inpati		Time of	3 DOA 28c. In	4 L. Ni		me 5 A Resid			cify)	
on c	ath. rr. Afte	icat	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation		y, Year) i	injury	W	orkí? □ Yes 2 □						
Division of Vital Records,	s after death	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined			ırm, stree	et, factory, offic	e		28f. Location (S City or Tow		Number or Ru	ıral Route Number,	
]	within 24 hours after deat  To the Funeral Director: completed filled in by the	Medical	(Check 2 Medical Exam	ysician: To the best of niner: On the basis of e rse Practioner: To the	xamination and/o	or investi	gation, in my op	nion, death o	curred at	the time, date a	ind place, a	and due to the	cause(s) and manner stated.	
ا و	withi To the	-	29b. Signature and title of certifier				29c. Lice	3420			29d. Date	signed (Mont	h, Day, Year)	
	10					Type, Pr	Su, Ke C	Var	retts	ville /	no	2108	4.	
	Stat Registra		31. Date filed (Month, Day, Year)  AUG 10 2010	378 Norr	Signature	KN	•							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 0 25050 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jul 25 Physician/ 201<u>0</u> Ronald Elwood Rvan 9:50 PMM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 17900 Williams Road Flintstone Allegany 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days Min Hours **Director** Mav 217-28-9084 76 Usual Residence of Deceden or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 10d. Inside City Limits MD Allegany Flintstone 1 XYes 2 No 10e. Street and Number ö 10f. Zip Code must be r 10g, Citizen of What Country? Funeral 17900 Williams Road 21530 USA "natural", or items ? edical Examiner mu 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates. 3 □**x**Widowed 4 □ Divorced Specify: Completed white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medicone. 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) owner/operator Ronnie's Glass Shop Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William M. Ryan Martha V. (Corwell) Ryan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Zondra Ryan daughteh MD 21555 18415 Lemuel Drive Oldtown 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Restlawn Memorial Gardens 7/28/201b LaVale MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign wire of Funeral Sept 28 Licensee 22. Name and Address of Eacility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition mon Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Dim to for as a nonsequence of If any heading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy
5 Other (specify) \_\_\_ Month Day Pregnant at time of death Year g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy performed certificate 1 Yes 2 No Yes 2 To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 00 Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify After this 28a. Date of injury (Month, Day, Year) eral Director: After th filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural injury 5 Pending Accident Investigation 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

32. Registr

1250

25051

			1 - State Registrar		Cei	rtificate of	Death		Reg. No.	010	23031
			Decedent's Name (First, Middle, La	ast)				2. Date of De Month	eath Day	Year	3. Time of Death
	Physici /Medic		Francis A. Ridg	ell				July 2			12:00 p M
1	Examir		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, or	r Location of Death		4c. C	ounty of Death	
10			1405 Billman Lan	e		Silver	Spring		M	ontgome	ry
	Funeral			Sex 7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	rth ay, Year)	Cou	place (State or Foreign
	Director		577-22-7725	1114 21 F   87	Yrs.			Nov. 1	.2 <b>,</b> 19	22 D.C	
	pu. w		Usual Residence of Decedent  10a. State 10b. County	100 City	Town or Lo	cation				1.	I0d. Inside City Limits
	shor	5									1 ☐ Yes 2 No
	he M	ect		tgomery S	ilver	Spring 10f. Zip Code			10a Citiza	en of What Cou	ntn/?
	a or	ä	10e. Street and Number 1405 Billman La	no		20902			USA	sii oi vvijat cou	intry :
	s 23	Funeral Director		12. Was Decedent Ever in U.S	12.1		lispanic Origin? (Sp	ocify Vos or N		I. Race - Ameri	can Indian
	item item	Ë	11. Marital Status  1 Never Married Married	Armed Forces?	. 13. 1	If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)		Black, White,	
21215-0036	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Eventher must be nottfled at		3 Widowed 4 Divorced	If Yes, Give Year or Dates: 1943-		1 □Yes 2√□No	Specify:		S	Specify: Wh	ite
ŏ	2 hou	Completed by	15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	pation		16b. Kind	d of Business/In	dustry
215	7. nin 7.	ble	(Specify only highest gr	College (1-4or 5+)	(Give life. L	kind of work done of DO NOT use retired	during most of work d)	ing	1		
21;	filed within Hygiene. Ither than "	ě	Elementary/Secondary (0-12)	Ochege (1-401-04)	Bank	Officer				Banki	ng
р	e filed y al Hygid other vent, tt	Be	17. Father's Name (First, Middle, Las	t)			18. Mother's Name	e (First, Middle	e, Maiden S	urname)	
/lai	uld b Menta Irked Itic e	2	Percy Ridgell				Edna S	Schultz			
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Thy dical Exerciting to rectify at	ľ	19a. Informant's Name/Relationship Audrey Ridgell/				and Number or Rui				
	1 and 2 Health em 27 i		20a. Method of Disposition	20b. Pla	ace of Dispo	sition (Name of	1	Date	20c. Loca	ation - City or To	own, State
<u>o</u>	Pages ment of I ant: If ite ury or of		1 🏝 Burial 2 🗆 Cremation 3 🏻	」Removal from State		matory or other plac Heaven Ce	ometery Ju	11y 28 2010	Cil	m Comin	~ Massins
Baltimore,	교린원들	ļ,	4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lice	-97			<u> </u>				g,Maryland
Ba	Deparation of the parameter of the param		15262	w	F1	rancis J. 00 Univer	ss of Facility Collins	Funera	1 Home	e Inc. r Sprin	g, MD 2090:
			23a. Part I, Enter the disease, or cor	nplications that caused the death.							Approximate
	Physician		shock, or heart failure. List only Immediate Cause (Final							4	Interval Between Onset and Death
-	/Medical		disease or condition resulting in death)	a. Coronary Art  Due to (or as a conseque		isease					
1	Examiner			Duo to for do d concedar	01100 017.						
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a conseque	ence of):						
6	outed ansit	Examiner	Cause (Disease or injury	C							
0,	an ar rial-tr	EX	resulting in death) Last	Due to (or as a conseque	ence of):						
68760, (	ficate be executed physician and s the burial-transit	cal		d							
68	certificate be executed thing physician and ise as the burial-transit	Medical									
			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal		☐ Ectopic pregnand	CV.		23	3d. Date of deliv	*
Э. В	dea ne att	Sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of de		Other (specify)				Month	Day Year
P.0	Physician: The law requires that the death this certificate has been signed by the atterral director, page 2 should be detached for u	Physician	9 ☐ Unknown			***					
Ś	res th iigned be de	b	Part II. Other significant conditions	contributing to death but not resul	ting in the u	nderlying cause giv	en in Part I.				the cause of death?
ord	w require been signature should b							1	Yes 24	JNo 3∐ Pro	bably 4 Unknown
ec	e 2 sh	Completed						24a. Wa	s an opsy	24b. Were aut	opsy findings available ompletion of cause of
<b>8</b>	The page	E O						per	formed? 2 🐼 No	death? 1 ☐ Yes	
ita	hysiclan: Th nis certificate I director, pag	Be (	25. Was case referred to medical examiner?				26. Place of Deat	th (Check only	one)		
of Vital Records,	hysic his ce I dire		1 Yes 2 No	Hospital: 1   Inpatient 2   E	ER/Outpatier	nt 3 □ DOA Oth	ner: 4 🗆 Nursing H	ome 5 <b>X</b> Res	sidence 6	☐Other (Spec	ify)
	ding Ph h. After th funeral	Certification: To	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time o Injury	f 28c. Inju Wor	ry at k?	28d. Describe	how injury	occurred	
Sio	r Attending Fer death. rector: After by the funer	cati	2 ☐ Accident investigation				]Yes 2□No				
Division	or Att	ŧ	3 ☐ Suicide 6 ☐ Could not determined		ne, farm, str )	eet, factory, office		28f. Location City or To	(Street and wn, State)	Number or Rui	ral Route Number,
	ital curs at ral D		<b>y</b>								
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical		hysician: To the best of my know miner: On the basis of examinati and manner stated.							
	o the	Mec	29b. Signature and title of certifier	one manner stated.		29c. Licens	se number		29d. Date	signed (Month	, Day, Year)
	- SFO		160 W	- ~ C . A		D23	459		.T11 7	y 26, 2	010
	1011		30. Name and address of person who	completed cause of death fitem	23a) (Type				- Jul	, 20, 2	
			Edward Taubman	, MD 18109 P	rince		rive, Olr	ney, MD	2083	2	
	Sta Registi		31. Date filed (Month, Day, Year) <b>JUL</b> 27 201	82. Registrar's Signate	par	w					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>010</u> Physician/ Emily Anne Rucker AM3:25 July Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Cherry Lane Nursing Home Laurel Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min. Washington, Director 579-26-6824 90 1920 February Usual Residence of Decedent or 28a-f shov notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Riverdale 1 X Yes 2 No Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ò "natural", or items 23a o Funeral with USA 6601 Auburn Avenue 20737 permit. Page 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Andrew Houston Margaret Frye 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph W. Rucker / Son 12317 Rambling Lane, Bowie, MD 20715 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Mt. Olivet Cemetery 8/3/2010 Washington, DC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundral Service Licenses 4739 Baltimore Avenue 22. Name and Address of Facility my Gasch's Funeral Home, PA Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Congestive Heart Failure Medical resulting in death) Due to (or as a consequence of) Examiner Atrial Fibrillation Sequentially list conditions Examine Due to lor as a consequence of cause. Enter Underlying physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury Chronic Kidney Disease that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) 2 🔀 No Part 1l. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Dysphagia 24a. Was an has autopsy performed? Yes 2 No page 2 this certificate the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 🗷 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital: 1 Yes 2 X No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d, Describe how injury occurred After injury 1 X Natural 5 Pending Accident Investigation after death Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by tt 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 005964 26. JULY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ikechukwu Damian Mbonu, 10801 Hickory Ridge Road, Columbia, MD 21044 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		Please  1 - State Registrar	State of Marylan	d / Depa		Health and	Mental Hy		2016	25053
Physicia Medic Examin	al	Decedent's Name (First, Middle, Land RICHARD C. ROBER     4a. Facility Name (if not institution, give)	TS		4b. City, Town, o	r Location of Deat	2. Date of De Month 07	ath Day		3. Time of Death 2:30 A M
Funeral Director			TAL Sex 1 [XM 2 □ F   7. Age (In yrs. In 75)	ast birthday) Yrs.	SILVER S If Under 1 Year Months Days	SPRING  If Under 24 Hrs Hours Min.	8. Date of Bir (Month, Da 04/19/	th	NTGOMEF 9. Bi OHIC	aboles Carter of Francisco
e Maryland r 28a-f show notified at	Director	10a. State 10b. County MD PRINCE G		y, Town or Loc				40.000		10d. Inside City Limits 1 Yes 2 No
	by Funeral Director	910 APPLEWOOD ST  11. Marital Status  1 □ Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces?	11	20743  Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S <sub>l</sub> an, Mexican, Puert	ecify Yes or No-	USA	izen of What C 14. Race - Am Black, Whi	erican Indian, te, etc.
72 hours afte	Completed b	3 Widowed 4 Divorced  15. Decedent's (Specify only highest g		16a. Deced (Give I life. Do	Yes 2XXNo  dent's Usual Occup kind of work done of NOT use retired)	ation during most of wor	-	16b. Ki	Specify: BLA	Industry
Idio A 12 I be filed within lental Hygiene rked other the tic event, the	To Be Co	12 TH  17. Father's Name (First, Middle, Last)  CLARK ROBERTS	College (1-4 or 5+)	SCH00	L BUS DR		ne (First, Middle,			RANSPORTATION
e, Mally and 2 should Health and M tem 27 is ma		19a. Informant's Name/Relationship ( DELORES M. ROBERT 20a. Method of Disposition	S/WIFE	910 A	ng Address (Street and PPLEWOOD sition (Name of			HEIG		20743
permit. Page 1 Department of Important: If it any injury or o		1 No Burial 2 Cremation 3 E 4 Donation 5 Other (Spec	Removal from State MAR	YLAND 22	NATIONAL  Name and Addres  08 SUITL	07/30 ss of Facility MA	0/2010 RSHALL'S	LAUR FUN	EL, MD ERAL HO	OME
be eg	ical Examiner	23a. Part 1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	a. ACUTE RESPI Due to (or as a consequence)	RATORY ence of): HALOPA	FAILURE					Approximate Interval Between Onset and Death
Attending Physician: The law requires that the death certificate to redeath.  setor: After this certificate has been signed by the attending physic by the funeral director, page 2 should be detached for use as the least the law of the funeral director.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnal 1  Live Birth 2 Feta 4 Pregnant at time of d 9 Unknown	Ideath 3 🗌	Ectopic pregnance Other (specify)	у		2	23d. Date of de Month	elivery Day Year
requires that the death been signed by the atteshould be detached for	<u>`</u>	Part II. Other significant conditions o	contributing to death but not resu	ulting in the ur	nderlying cause giv	en in Part I.	1 🗆 🕆	Yes 2	□No 3□F	o the cause of death? Probably 4 H Unknown
ician: The law r	be Completed	25. Was case referred to medical			26. Pla	ace of Death (Che	1 🗆 Yes	rmęd?	prior to death?	utopsy findings available completion of cause of
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	ا ⊵	examiner?  1  Yes 2  No  27. Manner of Death  1  Natural 5  Pending 2  Accident Investigatio	(Month, Day, Year)	ER/Outpatient 28b. Time of injury	28c. Injury work	4 L Nursing H	ome 5 Resid			sify)
spital or Att		3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)			date and place, a	City or Tow	n, State)		aral Route Number,
To the Ho within 24 h To the Fu	Medical	(Check 2 Medical Examonly one) 3 Certifying Nur	iner: On the basis of examination se Practioner: To the best of my	and/or investi	gation, in my opinio leath occurred at the 29c. License	n, death occurred a time, date and pla	at the time, date a ice, and due to the	nd place, e cause(s) 29d. Date	and due to the	cause(s) and manner stated. s stated.
State Registrar		30. Name and address of person who FARAH ABDULSALAM 31. Date filed (Month, Day, Year) JUL 2 8 2010		T GLEN	N RD., SI	LVER SPR	ING, MD	2091	.0	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 10:40PM GEORGE EDWARD SHERWOOD, JR. 20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death **DORCHESTER** 5923 NEWHART MILL RD. GALESTOWN Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 1 1/1/1933 MARYLAND 1 🔀 M 2 🗆 F Months Days Min. Yrs. **Director** 214-32-1411 Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits Directo MARYLAND DORCHESTER **GALESTOWN** 1 Tyes 2 X No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o edical Examiner must be Funeral and 2 should be filed within 72 hours after death with 1 Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a 5923 NEWHART MILL RD. 19973 **USA** 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 Divorced Specify: Completed WHITE Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **INSULATOR** 12 MANUFACTURING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည GEORGE E. SHERWOOD ANNA RUTH (MAIDEN NAME UNKNOWN) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MERLYN SHERWOOD / WIFE 5923 NEWHART MILL RD., SEAFORD, DE 19973 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/2/2010 CAMBRIDGE, MD MID SHORE CREMATION CENTER 21. Signature of Funeral Sec 22. Name and Address of Facility MID SHORE CREMATION CENTER 2272 HUDSON RD., CAMBRIDGE, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ ANCREA Tic Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time of the recognition 23b. Was decedent pregnant 23d. Date of delivery 3 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year g Unknown g Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 2 KNo the Hospital or Attending Physician: The sin 24 hours after death.

The Funeral Director: After this certificat notested filled in by the funeral director, ps 1  $\square$  Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending injury 1 Yes 2 No Accident M Investigation within 24 hours after de To the Funeral Director completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Aertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License numbe D005 8410

etl

State Registrar Sitterny

31. Date filed (Month, Day, Year)

e Sherwood

SANBULY IND 21802

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P.0

32. Registrar's Signature

WAM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day つさ Schill 1420 Dorothy Charlotte 2010 Medical 4a. Facility Name (if not institution, give street and number)
Howard County General Hospital 4c. County of Beath Howard 4b. City, Town, or Location of Death Examiner . Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Min. (Month, Day, April 28 1 □ M 2 🔽 F Hours 80 Director 173-22-8241 Usual Residence of Decedent or 28a-f show notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Maryland Columbia Howard 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral LISA 6220 R Foreland Garth 21045 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: If Yes, Give Year or Dates White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n. any injury or other traumatic event, the Medic once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lawrence E. O' Keefe Kathryn Stutz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward L Scholl - Son 692 Stratford Green, Avondale Estates, GA 30002 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory, Inc. 07/23/2010 Glen Burnie, Maryland . Signature of Funeral Servic License 22. Name and Address of Facility Fleck Funeral Home. Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707 M01283 23a. Part 1. Enter the disease or complications that caused shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Fhysician/ disease or condition resulting in death) Numohia Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Pleural effusion, re current 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed Preumothorax 24b. Were autopsy findings available prior to completion of cause of 24a. Was an errar after death.

erral Director: After this certificate has t filled in by the funeral director, page 2 s performed? death? Yes 2 No 1 Yes 2 40 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 2 1 No 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DOO 66515 20 2010 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D 5755 Cedar Lane, Columbia, Maryland 21044 Rawa,

State

Registrar

31. Date filed (Month, Day, Year)

JUL 26 2010

32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [ ] State Registra MEND#10eperFH7/29/10, BWW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 07/23/2010 MELVIN JOHN SMITH 12:38 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Collingswood Nursing Home Montgomery Rockville If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) . Social Security Number . Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 XM 2 Hours 07/29/1928 Director 218-24-0459 81 DC Usual Residence of Decedent 23a or 28a-f show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Howard Laurel 10e. Street and Number Breamore 9348 <del>Breadmore</del> Court 10f. Zip Code 10g. Citizen of What Country? Funeral 20723 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? 1 Never Married 2 Married ð 1 Yes : Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates ed other than "natu event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other than 9th Truck Driver W. Perry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Melvin T. Smith Irene Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra Crystal Smith - daughter 12923 Big Horn Drive, Silver Spring, MD 20904 20b. Place of Disposition (Name of certetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donetion 5 ☐ Other (Specify) Suitland, MD Memorial Cem: 7/29/10 22. Name and Address of Facility Snowden Funeral Home Funeral Service Li 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or shock, or heart failure. List o . Do not enter the mode of dying, such as cardiac or respiratory arrest, fications that caused the dea Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Physician/Medical Examine or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Month Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has autopsy death? Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Tyes Other 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier D0062435 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 101

State Registrar 31. Date filed (Month)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25057 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July <sup>Day</sup> 2010 25 James Edward Smith 3:30 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death 15301 Seneca Road Montgomery Germantown . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F July 19,1944 Days Hours 214-42-5602 Maryland **Director** 66 Usual Residence of Decedent 28a-f show 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at with the Maryland 10c. City, Town or Location 10d. Inside City Limits Direct Germantown Maryland Montgomery 1 Tes 2 X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20874 15301 Seneca Road within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Baltimore, Maryland 21215-0036
Permit. Page 1 and 2 should be filed within 72 hours after dex
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or ite
any injury or other traumatic event, the Medical Examine
once. Black, White, etc Yes 2 X No Yes, Give þ 1 Never Married 2 X Married 1 Tes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Printing Book Binder Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Mazie Mae Fuller Walter Wilson Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Germantown, MD 20874 Margarite Ann Smith (Wife) 15301 Seneca Road 20a. Method of Disposition 20b. Place of Disposition (Name of July 29, 20c. Location - City or Town, State cemetery, crematory or other place) X Burial 2 Cremation 3 Removal from State Rockville, MD Parklawn Mem. Pk. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundral Service License 22. Name and Address of Facility DeVol Funeral Home urtra 10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Physician. Lung Cancer - Small Cell Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed bin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and repleted filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ Live Birth 2 Live at least Pregnant at time of death in the past 12 months?
1 Yes 2 No Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Cher (Specify) Hospital 욘 1 🗌 Yes 2 💢 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pendina work 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 To the I within 2 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and t e of certifie 29c. License number 29d. Date signed (Month, Day, Year) July 26, 2010 wi D35635 Oj

Registrar
DHMH 17 Rev 7/2009

State

18111 Prince Phillip Drive #327

Olney, MD 20832

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3. Registrar's Signature

Dr. Joseph Kaplan M.D.

27

31. Date filed (Month, Day, Year)

JUL

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Monti

7600 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25059 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death  $J_{\boldsymbol{u}}^{\text{Month}}$ <sup>Day</sup>010 Physician/ 16, 8:18 Рм Lonnie Townsend, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 409 Blandfor Street #2 <u>Rockville</u> 8. Date of Birth (Month, Day, Year) Dec. 23, 1946 Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** Months 1 🕱 M 2 🗆 F Georgia 63 Director 255-72-2832 Usual Residence of Decedent Show 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State Director 1 X Yes 2 No Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20850 United States 409 Blandford Street, #2 death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 Black, White, etc. 1 Area 1 Closs 1 1 Area 2 1 968-If Yes, Give 1 968-Year or Dates. þ 1 Never Married 2 X Married Maryland 21215-0036 72 hours after 1 Yes 2 No Specify: Specify: Black "natural", 3 Divorced 4 Divorced Completed event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit Page 1 and 2 should be filed within 72 permit. Page 1 and 2 should be filed within 72 bepartment of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Department of Defense Elementary/Seconday (0-12) College (1-4 or 5+) Senior Architect Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ethel Woods Lonnie Townsend, Sr. 19a. Informant's Name/Relationship (Type, Print) 20850 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 409 Blandford Street, Apartment2 Rockville, Maryland Edna Townsend/Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🗌 Burial 2 🛣 Cremation 3 🔲 Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory 07/23/2010 | Beltsville, Maryland Signatur of Funeral Service Acense 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Avenue, N.W. Washington, D.C. 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final NON-SHALL CELL LUNG CANCER Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner BUNE METASTASIS Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): ending physician a use as the burial Physician/Medical Box 68760 the attending posterior that the state of th IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Year 4 Pregnant
9 Unknown Pregnant at time of death 1 Yes 2 No P.O. I s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy Physician: The certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 X No Division of Vital director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After the completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical

Registrar

State

29a. Certifier

(Check

only one)

31. Date filed (Month, Day, Year)

Uso/M

37. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MELVIN W. GASICIAS, MD 7831 BELLE POINT DK. GIVENBELL, MD 20778

Certifying Nurse Practions: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D43162

29d. Date signed (Month, Day, Year) 7/20/10

State of Maryland / Department of Health and Mental Hygiene 25060 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 24, 2010 5:09 P M G. Russell Taylor Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Worcester 3 A Bluebill Court Ocean Pines Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country) PA Months Days Hours Aug Month 3 Pay, Year 923 189-12-7096 86 Director Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location with the Maryland notified at Director 1 Yes 2 No 28a-f MD Worcester Ocean Pines 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be n Funeral 3 A Bluebill Court 21811 USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian Examiner Armed Forces? Black, White, etc. ö Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: If Yes, Give Year or Dates white "natural", WWII 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry permit, Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Nuclear Chemist Westinghouse Corp. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Rachel Chilcott George Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) A Bluebill Court Ocean Pines, MD 21811 Agnes G. Taylor- Wife 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Cape Henlopen Crem. 7-26-10 Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licenses 22. Name and Address of Facility 22. Name and Address of Facility Burbage Funeral Home 108 William Street Berlin, MD 21811 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to ( r as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. and burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE: **To the Funeral Director.** After this certificate has been signed by the attendin completed filled in by the funeral director, page 2 should be detached for use: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death
Unknown 5 Other (specify) 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral L Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Name and address of person who completed OceAN View, DE BARDARA E.T 10+1 SochA 31. Date filed (Month, Day, Year) **JUL 27** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 25061 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Year Louise aren 845 TUL 010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore niv. of Maryland Med. Baltimore 9. Birthplace (State or Foreign Country)
MD 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🏋 F Days Hours Min. Director 54 214-70-8870 10-14-1955 ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Caroline Denton MD10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 111 North Third Street 21629 ural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2X No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes M No Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event; the Medical Exa If Yes, Give Specify Black 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland Dutreach Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George R. Toliver, Jr. Edith C. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 47 Village Circle, Denton, MD 21629 <u>Tina Brown/Daughter</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-29-2010 Denton, MD Spring Grove Cem Signature of Funeral Service Licenses 22. Name and Address of Facility 917 W. Isabella St. Bennie Smith 917 W. Isabella St. Part 1. Late the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sediate Cause (Final) Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Gastrointestinal Hemorrhage Medical Due to (or as a consequence of): **Examiner** Sequentially list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) \_\_\_\_ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year the P.0. ed by the signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Kenal Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Jas autopsy s certificate ha performed? Yes 2 \(\sigma\) No 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical director æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director, Af completed filled in by the fu М Accident Investigation 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 07,25,2010 22 S. Greene Street Baltimore MD 21201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

GARJAE

LAVIEN,

UMMC

Deptof Surgery

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25062 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year <u>Jeffrey M. Wolman</u> Medical Ju1v 10:04 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3944 Bel Pre Road, Apt Silver Spring Montgomery Social Security Number Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8 Date of Birth Days Hours (Month, Day, 1★ M 2 □ F 214-52-4349 Director Yrs. 18, 1951 Washington, DC Oct Usual Residence of Decedent 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f 1 X Yes 2 No MD Silver Spring Montgomery 6 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3944 Bel Pre Road, Apt 2 20906 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc ò δ 1 Never Married 2 Married Yes 2 XNo Yes, Give Maryland 21215-0036 filed within 72 hours after 1 Yes 2 No Specify: "natural", Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) the US Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked o ပ Page 1 and 2 should be Bernard Wolman Yvette Passman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Bruce C. Wolman/Brother 5220 Pooks Hill Road, Bethesda, Maryland 20814 permit. Page 1 and 2
Department of Health
Light stant: If item 2:
an iury or other tonce. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State King David Mem. Gdns. 7/22/2010 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and anzansky-Goldberg Memorial Chapels, Inc Signature of Funeral Service Licenses 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Sudden Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Coronary Artery Disease Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Arteriosclerotic Cardiovasculer Disease burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Diabetes 68760 IE EEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant Box 23d. Date of delivery Cother (specify) for in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy Month Day Year 4 Pregnant a Pregnant at time of death signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death?
1 Yes 2 XNo certificate Yes 2 X N Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 X Yes 2 □ No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) After this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: \_\_ 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After work?
1 Yes 2 No ✓ Natural 5 Pending injury Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) D0028064 July 21, 2010

DHMH 17 Rev 7/2009

State

Registrar

P.O.

5530 Wisconsin Avenue, Suite 515, Chevy Chase, MD 20815

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

Edward N. Bodurian.

(Month, Day, Year)

2010

		For State Registrar		State of IV	iaryian	ia / Depa <i>Cer</i>	artment of H tificate of D	eaith and eath	a Mental Hy	/giene Reg. No		25063
Physicia	ın/	1. Decedent's Nam	e (First, Middle	, Last) Lily Lu	ı Wa	10.0			2. Date of Dominate July		ay 2010 Year	3. Time of Death <b>2230</b> M
Medic Examin		4a. Facility Name (if	not institution	give street and number)	i wa	rig	4b. City, Town, or	Location of De			. County of Death	
Funcual		Montgom 5. Social Security N		neral Hospia		ast birthday)	If Under 1 Year	Olney If Under 24 H	Irs. 8. Date of Bi	rth		gomery place (State or Foreign
Funeral Director		095-32-1	482	1 □ M 2 🗓 F	95		Months Days		lin. (Month D		Cour	
show d at	tor	Usual Residence of 10a. State	10b. County		10c. Cit	y, Town or Loc	cation					10d. Inside City Limits
e Mary r 28a-f notifie	Jirec	Maryland 10e. Street and Nur		ntgomery				Silver	Spring			1 Yes 2 X No
with the	Funeral Director			hen Drive, ‡	<sup>‡</sup> 520		10f. Zip Code	20906		10g. Ci	tizen of What Coul	S.A.
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1 □ Never Marr		12. Was Decedent Armed Forces	Ever in U.S	S. 13. V	Vas Decedent of His Yes, specify Cuban	panic Origin? , Mexican, Pu	(Specify Yes or No erto Rican, etc.)		14. Race - Americ Black, White,	
urs afte :ural", d al Exan	Completed by	3 🛭 Widowed	4 Divorced	If Yes, Give Year or Dates.	ı NO	1	☐ Yes 2 🛣 No	Specify:			Specify:	Asian
72ho an "nat Medica	mple		cify only highe	nt's Education st grade completed)	E.\\	(Give k	ent's Usual Occupa kind of work done du D NOT use retired)		working	16b. k	kind of Business In	dustry
d withir lygiene ther than nt, the	Be Co	Elementary/Sec		College (1-4 or	>+)		Teach					ation
d be file dental H rrked o tic eve	D E	17. Father's Name (	rirst, iviladie, L Juen	,				18. Mother's f	Name (First, Middle Ch	, Maiden UN <b>G</b>	•	
should hand M 7 is ma trauma		19a. Informant's Na				1	g Address (Street ar			-		
1 and 2 of Healt item 2 other		Allan P. 20a. Method of Disp	position			lace of Dispos	Paddock sition (Name of	Ţ	Date		ocation - City or To	
: Page tment c tant: If jury or		4 Donation	5 Other S			te of t	atory or other place Leaven Cer	n. 07/	/28/2010	Sil	ver Spri	ng, MD
permit Depar Impor any in		21. Signature of Fu	neral Service L	Censee MOO	709		Name and Address 800 New H					,
		shock, or he	rt failure. List o	complications that cause nly one cause on each lin	ie.	h. Do not ente	r the mode of dying	, such as card	liac or respiratory a			Approximate Interval Between
Physician/ Medical		Immediate Cause ( disease or condition resulting in death)		a. Oreb	a consequ	ascu	las ac	cide	n4			Onset and Death
Examiner	<u>.</u>	Sequentially list co	nultions,	Acur	te 1	Tespi	ratory	· fee	iluse			
ansit	Examiner	if any, leading to in cause. Enter Under Cause (Disease or	rlying iinjury	Due to (or as	a consequ	ience of <b>y</b> .	O	V				
sate be executed physician and the burial-transit		that initiated events resulting in death) I		Due to (or as	a consequ	ience of):						
ficate b g physi as the b	<b>Nedical</b>			d								
ath certifica attending p	sician/N	IF FEMALE: 23b. Was decedent in the past 12	months?	23c. If yes, outcome 1  Live Birth 4  Pregnant	2 Feta	l death 3	Ectopic pregnancy Other (specify)				23d. Date of deliv-	ery Day Year
the dea by the a ached to	Physic	1 Yes 2 g Unknown	No	g 🗆 Unknown	at time or c	jeau 5 L	Other (specify)					
requires that the de been signed by the should be detached	by	Part II. Other signif	icant conditio	ns contributing to death I	but not res	ulting in the ur	nderlying cause give	n in Part I.			1 6	ne cause of death?  bably 4   Unknown
w requi	Completed								24a. Was	an	24b. Were auto	psy findings available mpletion of cause of
: The law cate has	Com	-							— auto perf 1 □ Yes	ormed?	death?	
Physician: this certificanal director, page 1	To Be	25. Was case referre examiner? 1 ☐ Yes 2		Hospital:	ient 2 🗆	ER/Outpatien	Other		heck only one)	donoo 6	C Other (Specific	d
ding Phy h. After this funeral c		27. Manner of Death	n 5 ☐ Pendin	28a. Date of inju	ıry	28b. Time of injury	28c. Injury work?	at	28d. Describe			)
Attend er death ector: / by the f	Certificate:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	Investig 6 Could I determi	not be 28e. Place of Inj			M 1 ☐ Y et, factory, office	es 2□No			d Number or Rural	Route Number,
pital or ours afte eral Din			-,	building, et			4		City or To			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the bunial-transit	Medical	(Check 2	Medical E	Physician: To the best of xaminer: On the basis of Nurse Practioner: To the	examination	and/or investi	gation, in my opinion	, death occurre	ed at the time, date	and place	, and due to the ca	use(s) and manner stated.
Voit Voin		29b. Signature and	title of dentifier	1 Hinl	Mi	Lordia	29c. License	number	11101	29d. Da	te signed (Month,	Daff, Year)
		30. Name and addre	ess of person v	who completed cause of					717	U	T/ as/	(0
- 01-4		31. Date filed (Monti	h, Day, Year)	1MANIA ** Registr	ar's Signat		Prince Ph	ilip D	rice, Oln	ey,	Maryland	20832
Stat Registra	-	1111	27 2	110	1	ure fact						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 25064 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 7 Physician/ 2010 Рм Gertrude Bratten 12:05 Frances Werkheiser Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico 5545 Morris Road Pittsville If Under 1 Year I If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😾 F Days Hours Min. 8-12-1929 Director Yrs 212-40-7897 80 Pennsylvania Usual Residence of Decedent 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Wicomico Pittsville ö 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 5545 Morris Road 21850 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Force or i Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 X No 1 ☐ Yes 2 X No Specify: White If Yes, Give Specify: "natural", 3 Divorced 4 Divorced Completed Year or Dates traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) than " Elementary/Seconday (0-12) College (1-4 or 5+) 9 Own Home Homemaker other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ပ္ Frank Werkheiser, Sr. Gertrude Merwarth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health William R. Bratten - Husband 545 Morris Road, Pittsville, Maryland 21850 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any Injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-30-2010 | Parsonsburg, Maryland Jerusalem Cemetery 21. Signature of Funeral Service Lice 22. Name and Address of Facility Bounds Funeral Home Salisbury, Maryland 21804 Main Street, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only give cause on each line. Interval Between 16 199141 Immediate Cause (Final disease or condition resulting in death) Onset and Death Carcinoma Ph\_sician/ б S Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it says each get of managements cause. Enter Underlying Examine Due to (or se a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last sician and burial-trans Due to (or as a consequence of) physician s the burial Physician/Medical that the death certificate be as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No ō Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed? Yes 2 N death? 1 Yes within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, it Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 🛣 Residence 6 🗌 Other (Specify) 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Matural work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one

State Registrar 29b. Signature and title of certifier

Justinian Ngaiza 31. Date filed (Month, Day, Year)

**JUL 27** 

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036

68760

Box

P.O.

Records,

of Vital

Division

Richard A Hensen Registrar's Signatur

D0066198

29d, Date signed (Month, Day, Year,

100E. Carroll St., Salisbury MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 25065 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ <sup>Day</sup>010 July 25, Abraham Zuckerman 6:00 p Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1**X** M 2 □ F Days Min. Hours 0271271908 New York 087-07-5165 Director 102 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? Funeral 3701 International Drive #238 20906 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: If Yes, Give Completed 3 X Widowed 4 Divorced WWII Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Construction/Developing permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the May injury or other traumatic event the May injury or other trauma Elementary/Seconday (0-12) College (1-4 or 5+) Company Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Barnett Zuckerman Anna Lipshutz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roger E. Zuckerman, son 10505 Stapleford Hall Drive, Potomac, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date washington Hebrew Congregation MemI Prk 07/27/2010 1 X Burial 2 Cremation 3 K Removal from State Donation 5 Other (Specify) 22 Name and Address of Facility Edward Sagel Funeral Direction, Inc. Signature of Funeral Service Licensee MO1255 1091 Rockville Pike, Rockville, Maryland 23a. Part 1. Enter the finance, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate 1 driegal Between Immediate Cause (Final Physician/ Aspiration Pneumonia disease or condition resulting in death) 1 month Medical Due to (or as a consequence of): less than Examiner Atrial Fibrillation month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine less than -transit Failure to thrive 1 month 1 Due to (or as a consequence of) the burial nding physician Physician/Medical P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for u 1 Live Birth 2 Fetal dear 4 Pregnant at time of death 9 Unknown in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 5 Other (specify) signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, cate has been sig page 2 should b Completed 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2**X** No • Hospital or Attending Physician: 24 hours after death. Funeral Director, After this certifica To Be 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Hospital 1 Yes 2 🙀 No 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🛣 Natural injury work?
1 Yes 2 No 5 Pending 2 Accident 3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number 4 Homicide Medical 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifie

31. Date filed (Month, Day, Year

JUL

avelhor

Dr. Chary Maheshwary,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signatur

29c. License number

D0068681

1500 Forest Glen Rd, Silver Spring, Maryland

29d. Date signed (Month, Day, Year)

July 26, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25066 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 23, 2010 Physician/ 3:50p M Mary Louise Zimmerman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Casey House Rockville Montgomery Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland 1 M 2 X F (Month, Day, Year) Hours Director 578-28-2147 88 Usual Residence of Decedent 28a-f shov Termit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits by Funeral Director 1 Yes 2 X No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3701 International Drive, #437 20906 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced Caucasian 15. Decedent's Education cify only highest grade completed, 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>-ile Clerk/Telephone Operator | National Security Agendy</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Vernon Etzler Ethel Irene Warner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7025 Mink Hollow Road, Highland, Maryland 20777 Larry W. Zimmerman - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕱 Burial 2 🗆 Cremation 3 🗆 Removal from State Olivet Cemetery 07/27/2010 | Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licenses 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Years Immediate Cause (Final Physician/ Chronic Obstructive Pulmonary Disease disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner One to (or as a consequence of) If any, leading to immediate To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

Certificate: To Be Completed by Physician/Medical

25. Was case referred to medical

2 X No

5 Pending

Investigation

determined

6 Could not be

1 🔲 Yes

27. Manner of Death

1 Natural

2 Accident

3 Suicide 4 Homicide

29a. Certifier

cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 【☑ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy  1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)  9 ☐ Unknown		23d. Date of deliv Month	,	⁄ear
Part II. Other significant condition	s contributing to death but not resulting in the underlying cause given in Part I.		use contribute to the		
		24a. Was an autopsy performed?	death?	mpletion of ca	

State Registrar

Medical

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date signed (Month, Day, Year)

28c. Injury at

1 ☐ Yes 2 ☐ No

D37142

26. Place of Death (Check only one)

Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\boxtimes$  Other (Specify) Hospice

28f. Location (Street and Number or Rural Route Number,

28d. Describe how injury occurred

person who completed cause of death (Item 23a) (Type, Print)

Geoffrey Ooleman, MD 6001 Muncaster Mill Road, Derwood, Maryland 20852

31. Date filed (Month, Day, Year) **JUL 27** 201 32. Registrar's Signature

28a. Date of injury (Month, Day, Year)

1 Inpatient 2 ER/Outpatient 3 DOA

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 25067 State of Maryland / Department of Health and Mental Hygiene 2 1 1 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Z:30/ M nderson 201 Medical 4c, County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Halethorpe Izabeth ente NYSING If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Sep 20, 1927 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 ☐ M 2 🔏 F Maryland 214-20-9380 **Director** Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Halethorpe Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 1219 Poplar Avenue 21227 United States Page 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: 3 Nidowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Assembly Wire Person Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental H John J. Stierstorfer Launa Temple Towles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Diana Jean Anderson/Daughter 1219 Poplar Avenue, Halethorpe, Maryland 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Removal from State Meadowridge Mem. Park 8/12/2010 Elkridge, Maryland Conation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final nulmonary 005 Ph\_sician/ disease or condition resulting in death) Medical Examiner Meni Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b, Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Day 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown typertension Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy pother idism 2 🗌 No Yes 2 No 1 Yes this certificate 25. Was dase referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 24 hours after death Funeral Director: Suicide 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed State Registrar

X DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		-	for State Registrar	State of Ivia	•	Certificate			workar i i	Reg. No	2010	25068
	Physicia	n/	1. Decedent's Name (First, Middle,	_ast)					2. Date of De	eath Da	av Year	3. Time of Death
	Medic	al		Waugh	A.	llen			Augus			2:00 P <sup>M</sup>
	Examin	er	4a. Facility Name (if not institution, g Genesis Elder C		ton Cent	-	rown, or <b>ltin</b>	Location of Death	1	40	c. County of Death	
-	Funeral			i. Sex 7. Age	(In yrs. last birtho			If Under 24 Hrs. Hours Min.		rth	g. Birtl	nplace (State or Foreign ntry)
	Director		553-34-8021	1 □ M 2 <b>X</b> F	83 Y	rs.	Days	Hours Willi.	May 15	19	27 Mas	sachusetts
	ind show at	or	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				_		10d. Inside City Limits
	Maryla 18a-f s tified	rect	Maryland n/a	1		Baltimo	re					1 😾 Yes 2 □ No
	a or 2 be no	iO le	10e. Street and Number			10f. Zip				10g. Ci	itizen of What Cou	untry?
	th with ms 23 must	Funeral Director	3309 Batavia Av			40 W - B I		21214	if-: Vee av No		United S	
	er dea or iter niner	by Fu	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Marrie</li></ul>	12. Was Decedent Ender Armed Forces? 1 ☐ Yes 2 🔀				spanic Origin? (Sp n, Mexican, Puert	o Rican, etc.)	-	14. Race - Amer Black, White	
5	filed within 72 hours after death with the Maryland al Hygiene 1 d al Hygiene than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at		3 Widowed 4 XDivorced	If Yes, Give Year or Dates.		1 🗌 Yes	2 <b>X</b> No	Specify:			Specify: Wh	nite
ה ה	72 hou "natu	Completed	15. Decedent (Specify only highest		1 (0	Decedent's Usua Give kind of wor ife. DO NOT use	k done d	ation luring most of wor	king	16b. K	Kind of Business I	ndustry
7	ithin in the interest in the i	Con	Elementary/Seconday (0-12)	College (1-4 or 5- <b>5+</b>	+) "	Teach					Educatio	nn l
2	filed v al Hyg al othe vent,	Be (	17. Father's Name (First, Middle, La			10101		18. Mother's Nar	ne (First, Middle			
<u> </u>	should be file h and Mental H 7 is marked o traumatic eve	잍	George Fra			_		Edi		rgar		
Mar	2 shou th and 27 is n traum		19a. Informant's Name/Relationship Cathleen Allen/			-					r Town, State, Zip	
ນົ	f Healt item 2		20a. Method of Disposition		20b. Place of D	Disposition (Nam	ne of		Date Date	$\overline{}$	Maryland Location - City or 1	
2	Page nent o ant: If ury or		1 ☐ Burial 2 🔀 Cremation 3 ☐ Other (Sp			crematory or or ourney			10/2010	Wo	odbine.	Maryland
Daltillion	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inportment of Health and Mental Hygiene. Incorporath: I firem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lic	опосе		Going	Home	* Cremati	on Serv	rice	P.O. Box	784
		32 7	23a. Par 1. Enter the disease, or c	Homeo							arksvill	e, MD 21029
	nysician/		shock, or heart failure. List on Immediate Cause (Final	y one cause on each line	the death. Boths	t officer the mode	or dying	g, 040// 45 54.4.a.s	or roop, arery a			Interval Between Onset and Death
	Medical		disease or condition resulting in death)	a. Due to (or as a	consequence of)	):						
	Examiner	<u>.</u>	Sequentially list conditions.	b	lnoum	va						
7	sit sa	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of)	Cal.		- //	1.1			
	xecute n and al-tran	Еха	that initiated events resulting in death) Last	C. Due to (or as a	consequence of	i:	ne.	nak	ment	( -		
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YOU	ath cei	cian/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 █ No	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at	2 Fetal death	3  Ectopic p 5  Other (sp		у		100	23d. Date of deli Month	very Day <b>Y</b> ear
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ָ בּ	s that I	by P	Part II. Other significant condition	1		the underlying o	ause giv	ren in Part I.				the cause of death?
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5	naw re has be re 2 sh	Completed								s an opsy formed?	24b. Were aut prior to c death?	opsy findings available completion of cause of
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NICAL NICAL	Pnysician: The laving this certificate has aral director, page 2	To Be	examiner? 1 🗌 Yes 2 🎞 Vo	Hospital:	ent 2 🗆 ER/Outp	patient 3 DC	Othe	er 🔪 🧸		idence (	6 ☐ Other (Speci	fy)
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INISIOIL	al or A s after I Direct d in by		4 Homicide determin	ed building, etc.		n, street, ractory	, onice		City or To			ai noute vainbei,
-	to the chospital or Attending Prlysician: The law requires that the clearn certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical Ex	Physician: To the best of raminer: On the basis of ex	amination and/or	investigation, in r	ny opinio	n, death occurred	at the time, date	and place	e, and due to the c	ause(s) and manner stated.
	o the i	ž	only one) 3 Certifying N 29b. Signature and title of certifier	lurse Practioner: To the b	pest of my knowled			e time, date and pla number	ace, and due to t		(s) and manner as a te signed (Month	
	- > - 0		· na		miz		DI	31464			01210	
			30. Name and address of person w	no completed cause of de				·				
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	Stat Registra		AUG 1 1 2010	Denver A	Signature							

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			For State	State of N	Maryland / Do				and M	-	_	2016	)	250	150
			Registrar  1. Decedent's Name (First, Middle, Last)  2. Date of Death								<del>)</del>	3. Time of			
Physician/ Medical Examiner			Mary C. Bluhm  August 6, 2010  August 6, 2010								r	3:00	P M		
				a. Facility Name (if not institution, give street and number)							4c.	County of De	ounty of Death		
			Stella Maris				imon					Baltin			
	Funera Directo		215-07-6968	. Sex 1 □ M 2 KF 7. A	ge (In yrs. last birtho	Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da 7/11/	h Year) 20	9. E Ma	Birthpla Co <i>untry</i> Bryl	ce (State of ) and	r Foreign
	nd how	٦	Usual Residence of Decedent  10a. State 10b. County	<del></del>	10c. City, Town o	r Location							100	d. Inside Cit	ty Limits
	anylar Ba-fs ified	Director	MD Howard	4	F11	cridge								1 🗌 Yes	2 X No
	the N or 28	وَّز	10e. Street and Number		1		o Code				10g. Cit	izen of What	Country	y?	
	s 23a	Funeral	6398 Forrest Ave		21075					USA					
	death item	F.	11. Marital Status	12. Was Decedent Armed Forces	t Ever in U.S. ?	13. Was Dece	dent of Hi cify Cuba	spanic Orig n, Mexican	gin? (Spe , Puerto	cify Yes or No- Rican, etc.)		14. Race - Ar Black, Wh			
n.	after	d by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 ₽ If Yes, Give Year or Dates.	No	1 🗌 Yes	2 No	Specify:				0	√hit		
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8 2	within 72 hours after death with the Maryland within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho er than "natural", or items 23a or 28a-f sho it the Medical Examiner must be notified at	Completed	(Specify only highest Elementary/Seconday (0-12)	Grade completed)  College (1-4 or	ì	live kind of wo e. DO NOT us	erk done d e retired)	uring most	t of worki	ng			-		
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, 2010 3:00 p.m. Maryland 21215,0036	be file ental H ked o	일	Walter F. Smit	•						e (First, Middle, .na E. L					
2010	nould Ind Me		19a. Informant's Name/Relationship		19b. N	Mailing Addres	s (Street a			l Route Numbe			Zip Cod	de)	
`` ≥	d 2 sk alth a n 27 is er tra		 Mrs. Margaret Kol	nler / Neid	ce 19	55 Vict	ory	Dr.	Balt	imore.	Mary	land 2	2122	27	
0 T	of He		20a. Method of Disposition  1 Description 3		20b. Place of D	isposition (Na	me of other plac	e)	[	Date	20c. Lo	ocation - City	or Tow	n, State	
AUGUST 6,	Page tment tant:		4 Donation 5 Other (Spe	ecify)	Loudon				8/10			imore,			ıd
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			23a. Part 1. Enter the disease, or co shock, or heart failure. List onl	omplications that caus y one cause on each li	ed the death. Do not	enter the mod	le of dying	g, such as	cardiac c	r respiratory ar	rest,		lr Ir	Approximate	ween
A	Physician	_	Immediate Cause (Final disease or condition	<b>_</b> a	T CANCER								1 9	Onset and D	Death
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687	sertific ding p	M/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne of pregnancy							23d. Date of	delivery	,	
Box 687	leath of atter	sicial	in the past 12 months? 1 ☐ Yes 2 <b>X</b> No		2 Fetal death at time of death	3   Ectopic 5  Other (s		У				Month	-		Year
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ž.	lysicie is cert direct	10 8	examiner? 1 🗌 Yes 2 👿 No	Hospital:	atient 2 🗆 ER/Outp	atient 3 🗆 D	Otho			me 5 🗆 Resid	dence 6	■ Other (Sp	ecify)	HOSP	[CE
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_	Hospit 24 hour Funera eted fille	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated at the time, date and place, and due to the cause(s) and manner stated.										nner stated.		
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1.			30. Name and address of person wh						. ==						
Q		tate	JACKIE JONES, C 31. Date filed (Month, Day, Year) AUG 112(	RNP 2300	DULANEY V trar's Signature	ALLEY I	RD.	TIMON	MUTV.	MD 210	093				
	Regis	trar	AUG 112	110 Carm	to pl. of	Parker									

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Horatio Phoenix Baltazar-Hunter 2. Date of Death 3. Time of Death Physician/ Month 19 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death UNIVERSIM OF MO MEDICIAL BALAMONE CTR RALNMERIE City Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 M M 2 D F Hours Months 219 87 5533 06/05/2010 Maryland Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel 1 Yes 2 X No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 226 Southerly Road 21225 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces 1 X Never Married 2 Married Black White etc. þ 1 Yes 2 X No Maryland 21215-0036 1 🔀 Yes 2 □ No Specify: Guatamala If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) None N/A should be filed with and Mental Hygien 7 is marked other ti Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jamie Baltazar Michelle Hunter permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Hunter / Mother 226 Southerly Road Baltimore, Maryland 21225 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date injury or 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Baltimore, Maryland MT. Carmel Cemetery 07/30/2010 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, option lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on one cause on each line Interval Between Immediate Cause (Final Qnset and Death Physician/ ANOXIC BRIN INNI disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 42D14C Sequentially list conditions, Examiner cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Dav Year Pregnant at time of death signed by the at d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed 1 ☐ Yes 2 ☐ No Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2. No 1 🗌 Yes မ 1 Dispatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1. Natural 5 Pending 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 1 Yes 2 No Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010 140) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) U.UIV. OF MD MEDICA 225 GLEW ST BALMONF, MD ERRY LTA. 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State aug 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Migdle, Last) 3. Time of Death Month Physician/ 18 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NIA altimare Vincent Year If Under 24 Hrs. Days Hours Min. 8. Date of Birth
(Month, Day, You)

(Month, Day, You) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Naryland 1 🗆 M 2 🕟 Months Days Director Usual Residence of Decedent items 23a or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location Funeral Director 1 Yes 2 ☐ No Homore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number idaewood 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S 14. Race - American Indian. 11. Marital Status Yes, specify Cuban, Mexican, Puerto Rican, etc. Armed Forces Black, White, etc. 1 Never Married 2 Married þ ☐ Yes 2 🗖 🗚o Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number etha mother <u> Johnson -</u> 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Surial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) plature of Funeral Service Licensee 22. Name and Address of Facility ND 2124 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respir shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ervical 2009 - present disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Liner Underlying Cause (Disease or linjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit 24 hours after death. Presentificate has been signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy completed filled in by the funeral director, page 2 perform ☐ Yes 2 No 1 Tes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 513/25 Hospital Other: 2 No 1 Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Expertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 10 29b. Signature and title of certifie

Registrar

State

Ave

Belvedere

Battimore

Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2401

West

Registrar's Sig

## Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

-	_ For	State of M	i <b>nt in Blac</b> aryland / [		ment of Hea	Ith and M	lental Hy		- 3		
	State Registrar	. = -		Certif	icate of Dea	th		Reg. No. 2	010	2507	
n/	Decedent's Name (First, Middle,						2. Date of Dea	oth Day	Year	3. Time of Death	
al	Charles G		5				August		2010	07:00 P M	
er	4a. Facility Name (if not institution, Baltimore Washi	-	al Cente		o. City, Town, or Loca Glen	ation of Death 1 Burnie	2		unty of Death		
			e (In yrs. last birt	hday) If	Under 1 Year If U	Inder 24 Hrs.	8. Date of Birt	h	Anne Arundel  9. Birthplace (State or Foreig		
	216-36-9529 1 Months Days Hours Min. Nov. 28 19								338 Country) MD		
Director	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location									10d. Inside City Limits	
	Maryland Anne Arundel Pasadena									1 Yes 2 No	
اً دُ									of What Cou		
5	1841 Choptank Road 21122								USA		
	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was	Decedent of Hispan s, specify Cuban, Me	cify Yes or No-		14. Race - American Indian,			
	1 Never Married 2 X Mam	ied 1 ☑ Yes 2 ☐ If Yes, Give	No	1	ir res, specify Cuban, Mexican, Puerto Rican 1 ☐ Yes 2 ☑ No Specify:				Black, White, etc.  Specify: White		
3 Widowed 4 Divorced Fear or Dates.  15. Decedent's Education 16a. Decedent's Usual Occupation											
Be Completed	(Specify only higher	st grade completed)		(Give kind	of work done during OT use retired)	16D. KING (	b. Kind of Business Industry				
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	17. Father's Name (First, Middle, L					Mother's Name			name)		
٩		ward Boort	s			Cecilia	a M:	iller			
-	19a. Informant's Name/Relationsh				ddress (Street and N					Code)	
	Penelope Boort  20a. Method of Disposition	s (spouse)	20b. Place o		hoptank R				1122 ion - City or 1	Town State	
	1 🗌 Burial 2 🖾 Cremation		cemete	ry, cremato	ry or other place) natory Inc	Aug.				Maryland	
	4 Donation 5 Other (S		110020	,	ame and Address of		.010				
	My S	4								Home, P.A.	
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between										
	Immediate Cause (Final disease or condition	Ar. u	te 1	Arc	lipe 1	Arrl	my th	mi	A	Onset and Death	
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	if any, leading to immediate Due to (or as a consequence of):										
	Cause (Disease or iinjury that initiated events c										
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		u.									
	IF FEMALE: 23b. Was decedent pregnant   23c. If yes, outcome of pregnancy   1								23d. Date of delivery		
	in the past 12 months?  1   Yes   2   No 9   Unknown  9   Unknown						Mor			nth Day Year	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of dea			
								1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Ur			
							24a. Was i	an 2	4b. Were aut	opsy findings available	
normal moo							autor		prior to death?	ompletion of cause of	
ı١	25. Was case referred to medical				26 Place o	of Death (Check		2X No	1 L Yes	2 No	
	exami∕ler? 1 <b>X</b> Yes 2 □ No	Hospital: 1 ☐ Inpat	ient 2 NER/OU	utpatient 3	Other:	☐ Nursing Ho		lence 6 🗆	Other (Speci	fv)	
	27. Manner of Death	28a. Date of inju	ury 28b. 7	Time of njury	28c. Injury at work?		28d. Describe h				
	2 Accident Investigation M 1 Yes 2 No										
Cermicale:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street City or Town, Street)								t and Number or Rural Route Number, tate)		
	29a Certifier 1 Certifying Physician: To the best of my knowledge death occurred at the time date and place and due to the cause(s) and manner as stated										
29 a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									ause(s) and manner stat		
5	29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number							29d. Date signed (Month. Day, Year)			
		605	4	8	21035						
INCOL	Malilles	not n									
	30. Name and address of person v	who completed cause of	death (Item 23a) (	Type, Print	), , , , ,	n	-7				
Inedic	William 1	who completed calls of o	death (Item 23a) (	Type, Print	5451	Amer	rieA	2	10.	35	
Medical	30. Name and address of person value (Month, Day, Year)	P. John	Sjm ?	Type, Print		Amer	rieA	2	10.	35	

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND ITEM#20a-c,22perFH,G906,8/30/2010,WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar 25073 Reg. No. 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 2010 Anthony Blazys 4:26 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 🛣 M 2 🗆 F Days (Month, Day, Year) an 4, 1932 Months Min. Hours 212-30-7159 Lithuania 78 Jan Director Usual Residence of Decedent shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Montgomery Takoma Park 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6500 Riggs Road 20783 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian. Armed Forces? Black, White, etc. δ 1 X Never Married 2 ☐ Married Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Corcoran Gallery of Elementary/Seconday (0-12) College (1-4 or 5+) 0 art installer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Antanas Blazys Marija Kerspyla 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Egidijus Marcinkeviciu - nephew 2 E. 270th Street; Euclid, Ohio 44312 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 A Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 8/14/2010 Silver Spring, Maryland Sign true of Euneral Ser P. Name and Address of Facility State Anatomy Hines - Rinaldi Funeral Home 222 11800 New Hampshire Ave Silv MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 No n signed by the a Id be detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 🗆 No 3 Probably 4 Unknown 1 Yes s been signal Were autopsy findings available prior to completion of cause of 24a. Was an ate has b page 2 s autopsy performe death? certificate | Yes 2 No 1 Yes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No ည 1 Inpatient 2 X ER/Outpatient 3 I DOA To the Hospital or Attending Phys within 24 hours after death.
 To the Funeral Director: After this a completed filled in by the funeral dil this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 Yes 2 No 2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and umber or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🔟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) AUGUST 6 person who completed cause of death (Item 23a) (Type, Print) 30. Name and address GREENBELT MARYLAND 2077 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 1 201 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 16a,b per fh g906 8-11-10 vt. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 10 Medical 4a. Facility Name (if not institution, give street and number 4b. City Town, or Location of Death 4c. County of Death Examiner Northwest Hospice Randallstown Balto Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral (Month, Day, 1 X M 2 ... F Months Days Min Country) 213-62-6548 Director 53 -1956 Usual Residence of Decedent shov 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Balto Pikesville 1 Yes XXNo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8324 Streamwood Drive 21208 S 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1XXNever Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12)
12th grade College (1-4 or 5+) **Disabled** Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Nesbitt Buckson Sarah Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Buckson-Brother 8324 Streamwood Drive Pikesville, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State commetery, crematory or other place)
King Memorial Pk 8-14-2010 Randallstown, MD 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility March East F/H 21. Signature of Funéral Service Licens 1101 E. North Avenue Balto, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each li Immediate Cause (Final disease or condition Physician erc Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner Davi to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has hown sinned by the Attachment of the Funeral Director. within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Dav Year Yes 2 No g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perforn death? 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2XINo 1 Yes Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident work? 1 ☐ Yes 2 ☐ No injury 5 Pending Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar amend 29c,30 per DVR g906 k Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 0900 AM Phoenix Kenzo Bolling Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner <u>Baltimore</u> <u>Greater Baltimore Medical</u> owson Social Security Number If Unde 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral 1 🖾 M 2 🗆 F Months Days Hours Min (Month, Day, Year, Country) Director 07/28/2010 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County death with the Maryland Director 1 Yes 2 No MD Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5226 Todd Avenue 21206 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. ģ 1 XNever Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: "natural" Completed 3 Divorced 4 Divorced Black traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) Infant 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I ည Bolling Jr. <u>Gam</u>ble Mitchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health 5226 Todd Avenue; Baltimore, Maryland 21206 Kecia Gamble - mother item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o ь 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify) In State 22. Name and Address of Facility State Anatomy Board Duneral Service di nagad ector 655 W. Baltimore Street; Baltimore, MD 21201 Enter the divease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final PREMATURE Physician/ NOW VIABLE disease or condition resulting in death) Medical 30 Mg Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) ng physician and as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy
5 Other (specify) ģ in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death page 2 should be detached 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has death? this certificate 1 ☐ Yes 2 ☐ No Yes 2 after death.

Director: After this certific d in by the funeral director, of Vital Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: ျှ 1 🗌 Yes 2 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of injury 28b. Time of 28c 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury 5 Pending 1 🛂 Natural Division 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number filled in by 4 Homicide determined within 24 hours at To the Funeral D To the Hospital Medical (Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifie 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 ☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 28/2010 D0046156 are NECHATOLOGIS TWO Marie Pane, MD. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21204 6BMC CHAPLES 44TIMOVE 31. Date filed (Month, Day, Year) State AUG 1

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25076 State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Bonnar August Physician/ 11:18 4 M 2010 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Johns Hoptins Barview Medical Cente 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs Funeral Min. Davs 1 M 2 D F Months Hours Director Ireland Aua 217-59-9098 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location death with the Maryland Director 1 Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21224 United States 7947 Wynbrook Road 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 2 No within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Specify: 3 Widowed 4 Divorced Completed White Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Health Care 4 Technician Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Houston other traumatic Patrick Bonnar Page 1 and 2 should I nent of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 7947 Wynbrook Road Baltimore, MD 21224 Bonnar /Wife Sylvia 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State injury or Aug 10 4 Donation 5 Other (Specify) 2010 Beltsville, Maryland <u>Chesapeake Crematory</u> 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Alternatives än Pastures Drive Towson Maryland 23a. Part 1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Retween Onset and Death Immediate Cause (Final disease or condition Physician/ Seplic Shock Medical resulting in death) Due to (or as a consequence of): Examiner NEU MONTA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Monic The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last physician als the burial-t Physician/Medical Box 68760 use as i IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown jo Month Day Year Pregnant at time of death 9 Unknown P.0. signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ transplant 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Therapeutic 24a. Was an IMM UNO SUPPRESSION autopsy performed Yes 2 To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, t Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 4064 çause of death (Item 23a) (Type, Print) 30. Name and address of persor who completed 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

AUG 1 1 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 08 2010 6:45 AMM Kenneth Jackson Clark, Jr Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death <u>Jarrettsvi</u>lle 1749 West Jarrettsville Road Harford If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Hours 11/05/1962 Country) Maryland Director 216-72-5454 47 Usual Residence of Decedent items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No MD Harford Jarrettsville 10f. Zip Code 10g. Citizen of What Country? Funeral 1749 West Jarrettsville Road 21084 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or Completed by 1 Never Married 2 X Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced Year or Dates should be filed within 72 hours 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiens Important: If item 27 is marked other than any injury or other traumatic event, the Men Baltimore City Elementary/Seconday (0-12) College (1-4 or 5+) Police Department 12 Baltimore City Policeman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kenneth Jackson Clark, Sr. Margaret Eugene Jenkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21084 19a. Informant's Name/Relationship (Type, Print) Lisa A. Clark (wife) 1749 West Jarrettsville Road - Jarrettsville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gardens of Faith Cem. 08/12/2010 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 00 11750 Belair Road - Kingsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final GLIOBL MULTIFORME Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for as a consequence of: if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Exami use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Yes 2 No g 🗌 Unknown 9 Unknown Division of Vital Records, P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕻 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform this certificate 1 ☐ Yes 2 ☐ No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes မ 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending work 1 Tes 2 No Investigation 6 Could not be 2 Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 the only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 066 HUGUST 09 ORLEANS STREET, 1M16, BALTIMORE, MD 21231 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOLDHOFF, MD Matthias 1550 31. Date filed (Month, Day, Year) 2. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

AUG 1 1 2010

		For State Registrar		•			/ Depa		t of H	ealth a		lental Hy	giene	201	0	25078	3
Physicia		1. Decedent's Name (First, Midde Cornwell Chris		2								2. Date of De Month July		Yea 201		3. Time of Death 1:00 A M	
/Medic Examin		4a. Facility Name (If not institution 1700 North Bi	on, give str	eet and nu	ımber)	-		,	Town, or				4c. Co	ounty of De	ath		
Funeral Director		5. Social Security Number 224–07–3951	6. Sex	/ 2□F	7. Age (/	In yrs. las 92	t birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Nov 17	1917 1917	9. B 7 Ma	Country	ce (State or Foreign y) Land	
Maryland f show	tor	Usual Residence of Decedent  10a. State 10b. Count  MD	у		10		Town or Lo				_				100	d. Inside City Limits 1 A Yes 2 No	
with the I 3a or 28a it be notifi	Funeral Director	10e. Street and Number 1700 N. Broa	dway					10f. Zip	Code				10g. Citize	n of What (	Country	y?	
ire, Mary laring ZIZIS-0030 stand 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, Ite Marked Eventing in the motified at	þ	11. Marital Status  1 Never Married 2 Ma 3 Widowed 4 Divorce	rried 12	. Was Dec Armed Fo 1 Yes If Yes, Gi Year or D	orces? 2 No ive		_		ent of Hi ify Cuba	ispanic Ori n, Mexicar Specify:		ecify Yes or No Rican, etc.)		. Race - Ar Black, Wh pecify: b	ite, etc	o	
within 72 hou ene. than "natura	Completed	15. Decede (Specify only high Elementary/Secondary (0-12)	est grade c	tion			life. I	dent's Usua kind of wor DO NOT us Lpping	k done o e retired	luring mos )	st of work	ing	16b. Kind	of Busines	s/Indu	stry <b>un</b>	
larylarid 2.12 2 should be filed within and Mental Hygiene. Is marked other than aumatic event, Italy	To Be Co	17. Father's Name (First, Middle Peter Christm						11 0		18. Mothe		e (First, Middle hnson	, Maiden St	urname)			_
# # B E E		19a. Informant's Name/Relation Estelle Chri			ife			0	,			al Route Numb Baltin	-				
paritinore, Mispermit. Pages 1 and 2 s Department of Health a Important: If item 27 is any injury or other trau		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☑ Donation 5 ☐ Other		noval from	State	20b. Pla cer	ce of Dispo netery, crer					Date		ation - City	or Tow	n, State	
permit, Depart Import any inj		21. Signature of Funeral Service ROnald	Licensee		bite	etor	22	2. Name an 655 V	d Addres	ss of Facili altim	<sub>ty</sub> Sta nore	te Anat Street;	Balt	soard :imore	-	íD 21201	
Physician /Medical		23a. Part Enter the dise se, shool or heart failure. List immediate suse (Final disease or confition resulting in death)	or complica st only one a.	cause on	caused the each line.	_	ancer		e of dyin	g, such as	cardiac	or respiratory a	rrest,		'	Approximate Interval Between Onset and Death	_
e be executed rsician and burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (useass or injury that initiated events resulting in death) Last	b. c.	Due to	(or as a c	conseque	nce of):										
<b>DUX 00</b> eath certificat attending phy for use as the	hysician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d.		birth 2[gnant at tir	Fetal	leath 3	☐ Ectopic p ☐ Other (sp		у			23	3d. Date of Month		y Day Year	
av requires that as been signed 2 should be det	ed by P	Part II. Other significant condi	tions contr	ibuting to o	death but r	not result	ing in the u	nderlying c	ause give	en in Part I	l.					e cause of death?	
al neco :: The law re cate has be ; page 2 sho	Completed	<u> </u>										24a. Was auto perfe 1 □Yes		prior death	to com	sy findings available ipletion of cause of	
ysician ysician nis certif	To Be	25. Was case referred to medic examiner?  1 ☐ Yes No	_	spital: 1	] Inpatient	2 🗆 E	R/Outpatie	nt 3 🗆 DC	Oth	or,		th <i>(Check only</i> ome 5		□Other (S	pecify	)	_
To the Hospital or Attending Physician: The law requires that the dwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Certification: T	3 ☐ Suicide 6 ☐ Could	tigation	ì	nth, Day, Y	(ear)	28b. Time o Injury ne, farm, str	М		yat <br Yes 2 □	]No	28d. Describe  28f. Location			Rural	Route Number,	
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the the	Medical Cert	29a. Certifier Certify	ring Physical Examine	cian: To the	ie best of i	my know	ledge, deat	h occurred	at the tir	me, date a	and place	, and due to the	e cause(s)	and manne place, and (	r as sta	ated. the cause(s)	_
To the within ? To the comple	Mec	29b. Signature and title of certif	ier	1/1	1 1 1		M		0 4	e number				signed (M		Day, Year)	-
		30. Name and address of person		1 tomo	and	th (Item	23a) (Type,	Print) Evf	ıw	Plac	٠,	Ralhiv	-6-24,	NO	;	21217	_
Sta Registr		31. Date filed (Month, Day Yea	1 20	10 32.	Registrar's	s Signatu	A. A	back									_

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	•	For State Registrar	State of Maryland			f Health and M of Death		ena 0 1 0	25079
Physicia		1. Decedent's Name (First, Middle, Last) George Joseph Clar	·k				2. Date of Death Month August	Day Yea	
/Medic Examin		4a. Facility Name (If not institution, give street Prince Georges Median	eet and number) lical Center		Chev		0		Georges
Funeral Director		217-44-7132	7. Age (In yrs. la	yrs.	If Under 1 Y Months Da	avs Hours Min.	8. Date of Birth (Month, Day, Oct 17,	Year) 1944 Wa	Sinthplace (State or Foreign Country) Ishington DC
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or itema 23s or 28s-f show eny fourty or other traumatic event, the Madical Examinations to contact the marked of the magnetic at a Madical Examinations.	ctor	Usual Residence of Decedent  10a. State 10b. County  MD Prince G		Town or Loc reenbe	1t				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
th with the 23a or 20	Funeral Director	109 Rosewood Driv			10f. Zip Co 207	70		USA	
urs after dea al', or items Examiner m	þ	11. Marital Status  1 ☑ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	11	Vas Decedent Yes, specify ☐ Yes 2⊠	of Hispanic Origin? (Sp Cuban, Mexican, Puerto No Specity:	ecify Yes or No- Rican, etc.)	Specify: V	
within 72 hor ane. Ithen "naturi ne Medical i	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	tion completed) College (1-4or 5+)	(Give life. L	ent's Usual O kind of work d OO NOT use n	lone during most of work etired)	ing 1	6b. Kind of Busine	ss/Industry unk
uld be filed i Aental Hygie rked other t Ilc event, th	To Be Co	17. Father's Name (First, Middle, Last) William Mason Cla	ark			18. Mother's Nam	e (First, Middle, M Marie We	aver	
and 2 shore ealth and N n 27 is mai		19a. Informant's Name/Relationship (Type Cathy Clark - si	ster	109	Rosew	rood Drive;	Greenbel	t, Maryla	and 20770
i. Pages 1 tment of He tant: If Iter		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rei 4 ☑ Donation 5 ☐ Other (Specify)	moval from State	metery, cren	sition (Name of natory or other			omy Loard	
Depar Impor eny In	1 /	21. Signature of Funeral S, rvice Licensee ROD 3 d S S S S S S S S S S S S S S S S S S	We		655 W.	Baltimore	Street;	Baltimor	e, MD 21201
Physician   Medical	dicai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	where of):  Heart  Hence of):  Hence of):	ar.	aligheres ection	)		Onset and Death
w requires thet the death certilicate be execu been signed by the attending physicien and should be detached for use as the burial-tra	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	ncy death 3	Ectopic pregi	nancy		23d. Date of Month	delivery Day Year
requires thet the seen signed by hould be detact	Ď	Part II. Other significant conditions control	nbuting to death but not resu	Ilting in the u	nderlying caus	se given in Part I.	23e. Did tob	2/	te to the cause of death?  Probably 4 Unknown
The lay ate has pege 2	Completed						24a. Was a autops perform	ned? deat	e autopsy findings available to completion of cause of h? Yes 2 \( \square\) No
To the Hospital or Attending Physician: In within 24 hours attendeath. To the Funeral Director: After this certificate completely filled in by the funeral director. peg	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No Ho  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	spital: 1 V Inpatient 2 U  28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury		Other		e) ence 6 Other (sow injury occurred	Specify)
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		eet, factory, o	office	28f. Location (Si City or Town		r Rural Route Number,
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	(Check only 2 Medical Examination)	cian: To the best of my knor er: On the basis of examinal and manner stated.	wledge, deat tion and/or in	h occurred at vestigation, in	the time, date and place my opinion, death occu	rred at the time, d	ate and place, and	due to the cause(s)
To t Withi To tl	Σ	29b. Signature applitude of certifier	Elmin		29c. L	icense number	7	August	1, 2010
		Offinell Cumber	npleted cause of death (Item	C.	Print)	hospital.	Ala C	henerly	he 201
Sta Regist	ate rar	31. Date filed (Month, Dey, Year) AUG 112010	32. Registrar's Signa	ture	Las	747		Ü	

0-05936	Please Type or Print in Black	Indelible Ink. Ensure All Copie	Ale Legible.
heodore Arandia C		epartment of Health and Mental H	ygiene
	Registrar	Certificate of Death	Reg. No. 2010 25081
Physician/ Medical Examiner	Decedent's Name (First, Middle, Last)     THEODORE ARANDIA C	ORWIN	2. Date of Death Month Day Year August 7, 2010  3. Time of Death 1545 hrs
	4a. Facility Name (if not institution, give street and number) University Hospital	4b. City, Town, or Location of Death Baltimore	4c. County of Death N/A
Funeral	5. Social Security Number 6. Sex 7. Age (In y	rs. last birthday) If Under 1 Year If Under 24Hrs	
Director		30 Yrs. Months Days Hours Min	03/27/1980 Foreign Country) MA
è	Usual Residence of Decedent  10a. State 10b. County 10c.	City, Town or Location	10d. Inside City Limits
Aaryland 28a-f show any 1 at once. ector		MIDDLE RIVER	1 Yes 2 No
the Maryland a or 28a-f sho vified at once.	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director		in U.S. 13. Was Decedent of Hispanic Origin? (Sp	U.S.A.  Decify Yes or No-  14. Race - American Indian, Black,
er death with , or items 23 r must be no	11. Marital Status 1 X Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Puerto	Prican, etc.)  White, etc.
r nus	1 Yes 2 A N	No 1 Yes 2 No specify:	Specify: WHITE
irs after tural" amine	or Dates:	d) 16a. Decedent's Usual Occupation (Give kind of v	
5-0036 ed within 72 hour Mygiene. other than "natu the Medical Exan Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use reti	
036 rithin and reserve	8	N/A	N/A
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medica TO Be Comple			e (First, Middle, Maiden Surname)
121; d be fill fental H tarked event,	PHADDEUS O. CORWIN  19a. Informant's Name/Relationship (Type, Print )	TERES	ITA ARANDIA Rural Route Number, City or Town, State, Zip Code)
MD 21 nd 2 should alth and Me am 27 is ma raumatic ev	TERESITA BALLARD/ MOTHE		E, MIDDLE RIVER, MD 21220
and 2 and 2 fealth item 2 traur	20a. Method of Disposition 2	20b. Place of Disposition (Name of cemetery,	Date 20c. Location - City or Town, State
Baltimore, permit. Pages 1 ar Department of Hec Important: If ite	1 Burial 2 X Cremation 3 Removal from State	crematory or other place) BAYVIEW CREMATORY 8/1	12/10 BALTIMORE, MARYLAND
altin nit. P sartme sortar	4 Donation 5 Other Specify: 21. Signature of Fund Service Licensee	2. Name and Address of Facility LILLY & ZEILER	
E D D E	Cana Determine	1 1901 EASTERN AV	VENUE, BALTIMORE, MD 21231
Physician	23a. Part I. Enter the disease, or complications that caused the d failure. List only one cause on each line.		Between Onset and
//////////////////////////////////////		of the Head with complications	Death
	h	ice of):	
Jer l	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequent	ice of):	
ted Insit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequent cause)	nce of):	
executed an and al - transit ical Ex			
D, be exessician sucian ourial -			Lood Date of delivery
68760, ertificate be ding physicia e as the burit an/Medi	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of 1 Live birth	pregnancy  2 Fetal death 3 Ectopic pregna	23d. Date of delivery ancy Month Day Year
OX 68 sath cert attendir for use a	past 12 months?  4 Pregnant at time		
b, Bo the dea by the a ched fo	Part II. Other significant conditions contributing to death but	not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
P.C.		not resulting in the underlying eadse given in Fact.	1 Yes 2 No 3 Probably 4 Unknown
Records, The law requires fircate has been signage 2 should be Completed			24a. Was an 24b. Were autopsy findings available prior to completion of cause of
eco he law tre has			performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
e C.	25. Was case referred to medical	26 Place of Death (Check	only one)
Vita	1 ✓ Yes 2 No		ng Home 5 Residence 6 Other:
n of ing Ph Affer t funeral	27. Manner of Death 1 Natural 5 Pending Aug 2, 2010	28b. Time of Injury 28c. Injury at Work?  1345 hrs 1 Yes 2 ✓ No	28d. Describe how injury occurred Subject assaulted
Sior Mtend death. ctor: by the i	Natural 5 Pending Aug 2, 2010  2 Accident Investigation	, 100 2	28f. Location (Street and Number or Rural Route Number, City
Division ospital or Attending hours after death. Inneral Director: After y filled in by the fune Certification:	3 Suicide 6 Could not be determined (Specify) Townsh	At home, farm, street, factory, office building, etc. ouse / Rowhouse	or Town, State) 1839 McHenry Street, Baltimore, MD
Lospits t hours unera ly fille		ouse / Nownouse wiledge, death occurred at the time, date and place, and	
To the Ho within 24 To the Fu completel	one)  Medical Examiner: On the basis of examinat and manner stated.	tion and/or investigation, in my opinion, death occurred	at the time, date and place, and due to the cause(s)
Me s region	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	( Laxlordon mu)	O.C.M.E.	August 8, 2010
	30. Name and address of person who completed cause of death		201
	Laron Locke MD. Assistant Medical Examin		201
State Registrai		A. Lake	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2010 Louise Walker Coleman 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltmore Count Baltimor Elderplus Assited Living If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Days Min. Months 1 □ M 2 🕱 F 80 12/11/29 Maryland 217-26-8698 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1∩a State 10h. County 1 ☐ Yes 2 No MD Baltimore Edgemere 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 2829 Lodge Farm Rd. USA 21219 14. Race · American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No Black, White, etc. 1 □Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper Housekeeping 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bessie Wilson Charles Coleman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12350 W. Monroe St. Avondale, AZ. 85323 Joyce Tuck / Neice 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore Crematory 8/9/10 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licebsee 3620 Wilkens Ave. Baltimore, maryland 21229 23a. Part 1. Enter ne disease, or cor plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on // ne cause on each line. Immediate Cause (Final severe month disease or condition resulting in death) Due to (or as a consequence of): demen Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last HIN Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1 □Yes 2XNo 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown -lipidemia 24b. Were autopsy findings available prior to completion of cause of death? performe 1 ☐Yes 2 No 1 ☐Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Assisted link 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran Division of Vital Records, P.O. Box 68760, cate has been signed by page 2 should be detach certificate has After this certific funeral director, death. within 24 hours after death

To the Funeral Director:
completely filled in by the f

the Hospital

Physician/Medical

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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**Funeral** 

Director

Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Wedical Examiner must be notified at

Department of Health ar Important: If Item 27 is any injury or other trau

**Physician** 

/Medical

Examiner

2 should be filed within 72 hours after on and Mental Hygiene.

Is marked other than "natural", or iter

Pages 1 and 2 should

21215-0036

Maryland

Saltimore.

Be Completed by Medical Certification: To 6 Could not be determined 3 Suicide 4 ☐ Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

21224

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Cru
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Rip (Maia Holden

MP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 2010 25082 State of Maryland / Department of Health and Mental Hygiene

		I- For State				Certific	cate of	Death	7				Reg. No	).			
Physiciar		Diondra Shantal Dugger  Diondra Shantal Dugger  2. Date of Death Month Day Year August 1, 2010  3. Time of Death 2006 hrs															
Medical Examin		Diondra S	hantal l	Dipper								August 1	, 2010	) Year		2006 hrs	
		4a. Facility Name (if			number)		- 4	b. City, To	own, or L	ocation o				c. County o	Death		T
		Sinai Hospit	al					Baltim	ore					n/	a		
Funoral	4	Social Security No.	umber	6. Sex	7. Age (I	n yrs. last bi	rthday)	If Unde	r 1 Year	If Under	r 24Hrs.	8. Date of I	Birth(MM			hplace (State or	٦
Funeral Director	- 1	150-88-4968	arribo.					Months		Hours					Foreign	n untra A	
Birector	L			1 M 2 F			_20 <sup>Yrs</sup>			L	السيا	2-7-	1990		COL	N.	_
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iffed to	Director	2952 Y	orkway						2	1222					USA		
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury, r other traumatic event, the Medical Examiner must be notified at once.	ᇛᅡ	11. Marital Status		12. Was D	ecedent Ev	er in U.S.						ify Yes or I	No-			can Indian, Black,	_
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Division of Vital Records, P.O. Box 68 rate or Attending Physician: The law requires that the death certifiers after death.  "al Director: After this certificate has been signed by the attending led in by the fineral director, page 2 should be detached for use as	ωl	25. Was case referre	ed to medica			- 5			_		Check on			1,000			
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y fill		4  Homicide  29a. Certifier									1	-					i
Division of Vital  To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director.	Medical		Certifying P Medical Exa	hysician: To the b miner:On the basi	est of my ki s of examin	nowledge, de ation and/or	eath occur investigat	ion, in my	opinion, o	death occ	ce, and di curred at t	he time, da	te and pl	lace, and du	e to the	cause(s)	
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	ŀ	30. Name and addre	ess of persor	who completed ca	use of deal	h (Item 23a)											
		Patricia Aror	nica-Polla	k MD. Assis	stant Med	dical Exar	miner	111 Pe	nn Stre	eet, Ba	ltimore,	MD 212	01				
Sta	ite	31. Date filed (Monti	h Day Year)	1 0040 32.	Registrar's	Signature	6 4	1	,				-				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dottera Month 2:55 A M August Physician Sanford 05 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore City The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 5. Social Security Number Age (In yrs. last birthday) **Funeral** 1 🙀 M 2 🗆 F 200-28-6511 74 York. June **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ms 23a or 28a-f sho must be notified at 1 ☐ Yes 2 XNo Director York PA York 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number USA 17403 204 Bunting Dr. Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) items ? 11. Marital Status "natural", or iten adical Examiner r 1 Yes 2 No
If Yes, Give 1955-59
Year or Dates 1 Never Married 2 X Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed er than "natur , the Medical ! 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Printing Press Operator Manufacturing 12 yrs. N/A 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be item 27 is marked of Elva Stevens Joseph Duttera ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trau 204 Bunting Dr. York, Pa. 17403 Norma Duttera (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Friedensaal's Cem. 20c. Location - City or Town, State Date 20a. Method of Disposition X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Seven Valleys , PA 8-9-2010 <sup>22. Name and Address of Facility</sup>l Home, Inc. Tassahn Funeral Home, Inc. 7401 Belair Road Baltimore,Maryland 21236 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final le u Kemia mueloid **Physician** acute disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, reading to in reading cause. Enter Underlying Cause (Disease or injury that initiated events Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 T Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA 1 🗌 Yes ၉ 28a. Date of Injury (Month, Day Year) 27. Mainner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined City or Town, State) 4 - Homicide Descritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature ap MD (PHO RES-000

X State

TIMOTHY FRUNKS MOJPHD 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

600 North Wolfe St, Baltimore, MD, 21287

2010

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene

		1	For State Registrar		State of Ma	aryianu .		riment of F	ieaith and iv Death	лентаг пу	Reg. No.	2010	25084		
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Me Exar	dica nine		4a. Facility Name (if not in Gilchrist Ce		reet and number)			4b. City, Town, or Towson	Location of Death	<u>.                                    </u>	4c. Ba	County of Death	n		
Fune Direct			5. Social Security Number 287 26 7143	1 🗆	м 2 <b>ж</b> F 85	(In yrs. last I	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir January	th y, 124 <sup>r)</sup> 19	9. Birth 1925 Balt	hplace (State or Foreign Imore, Maryland		
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with the M 23a or 28 ust be noti		.≒ L	10e. Street and Number 5929 Glenoak A					10f. Zip Code 21214			10g. Citi	izen of What Co	untry?		
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Maryland 21215-0036 2 should be filed within 72 hours after tht and Mental Hyglene. 27 is marked other than "natural", or reaumatic event, the Medical Exam		Completed		Decedent's Edi nly highest grad (0-12)			(Give k	ent's Usual Occupa ind of work done of NOT use retired)	ation luring most of work	ing	1	nd of Business I al <b>Securi</b>	<sub>Industry</sub> ty Administratio		
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baltimore, Marylar permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ear			20a. Method of Disposition  1  Burial 2  Cro 4  Donation 5	emation 3 🗆 i Other (Specify)	-	cem	etery, crem ey val		ns. August			imore, Mar			
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Division of Vital Reco To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2.		Certificate:		Could not be determined	28e. Place of Injubul		e, farm, stre	et, factory, office		28f. Location ( City or To			ral Route Number,		
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To T	,		29b. Signature and title o	w				29c. License	9 number 58303		AV	te signed (Month	h, Day, Year)		
(QV			30. Name and address of	30	AMURS	M	67	rint)	Chonce	- 55	TV	MOCH.	no		
Regi	Stat istra	e ir	31. Date filed (Month, Da	G 1 1 20		ar's Signature	1. 4	arkel							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 8:14 A. M Danny Leroy Dickey 2010 August /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel 4 N. Betty Street Laurel 9. Birthplace *(State or Foreign Country)*Maryland 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**™** M 2□ F Yrs 217 50 6527 60 09/30/1949 Director Usual Residence of Decedent 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location la or 28a-f show 10a. State 10b. County 1 ☐ Yes 2 🛣 No Anne Arundel Director Laurel Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20724 ral", or items 23a 4 N. Betty Street Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Yes 2 No Yes, Give 7 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Year or Dates: Viet Nam White 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th of Health and Mental Hygiene. College (1-4or 5+) Machine Operator / Laborer Locke Insulator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be æ Robert E. Dickey Sr. Pearl Goddard ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Laurel, Maryland 20724 4 N. Betty Street Bonnie Dickey / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 permit. Pages 1
Department of P
Important: If ite
any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 08/11/2010 Baltimore, Maryland Loudon Park Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fineral Service Licen 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any locality immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician the for use as the buria certificate be Physician/Medical IF FEMALE: 23d, Date of delivery yes, outcome of pregnancy 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No detached 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has 1 □Yes 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred e Hospital or Attending P 24 hours after death.
e Funeral Director: After t letely filled in by the funera After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifler Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0064178 August 09, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital Dr., Suite 312, Glen Burnie, MD SINGH, MD

Registrar

State

DHMH 17 Hay 1/2001

31. Date filed (Month, Day,

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical County of Death 4b. City, Town, or Location of Death 4c. **Examiner** HIMORE last birthday) Birthplace (State or Foreign Country) 8. Date of Birth Year If Under 24 Hrs Funeral Hours ReedSville. Yrs. Director show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Completed by Funeral Director 1 🗆 Yes 2 💢 No IMORE 10g. Citizen of What Country? 10e. Street and Numbe 2111 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. 11. Marital Status Was Deceuc... Armed Forces? 1 ☐ Yes 2 No Black, White, etc. 1 Never Married 2 Married 1 Yes 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within 72 Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) nome tomema Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coo 19a. Informant's Name/Relationship (Type, Print) Important: If item 2, any injury or any 10 COPSE 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) YORK Kond Monkton, MD2111 21. Signature of Funeral Service Licens REMATION SERVICES-Markton Approximate 23a. Part 1. Enter the disease, or d at caused the death shock, or heart failure. List o each line Interval Between Onset and Death Immediate Cause (Final) Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 215 Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown been signed by the atte should be detached for Month Dav Year 4 ☐ Pregnant : 9 ☐ Unknown Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed Yes 2 2 No certificate 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28b. Time of Manner of Death 28a. Date of injury 28c. Injury at 28d. Describe how Injury occurred Certificate: (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 5  $\square$  Pending 1 Natural Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 3 □ only one) 29c. License number 29b. Signature and title of certifie Adam Road Cockeysville MD 21030 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 54 SOUT SIMUN MD 31. Date filed (Month, Day, Year) 2. Registrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 00:25 AM Israel Milton Fleischer ANGUST 09 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** TOWSON BALTIMORE SAINT JOSEPH MEDICAL CENTER 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 6 Sex 7. Age (In yrs. last birthday) Funeral 1 XM 2 □ F Hours March 23,1937 Baltimore, MD. Days Min. 220-36-7574 73 **Director** Usual Residence of Decedent show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State with the Maryland Director notified 1 Yes 2 No 28a-f Maryland Baltimore Co. Lutherville 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number ms 23a or ō Funeral 21093 United States 1619 Greenspring Drive and Mental Hygiene.
is marked other than "natural", or items aumatic event, the Medical Examiner mu Page 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.

tant, if item 27 is marked other than "natural", or items uny or other traumatic event, the Medical Examiner mul uny or other traumatic event, the Medical Examiner mul 12. Was Decedent Ever in U.S. Armed Forces 2 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Black, White, etc. δ 1 Never Married 2 Married 1 Yes If Yes, Give 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: White 3 ☐Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Certified Public Accountant Accounting 04 Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) ဂ္ဂ Louis Fleischer Dora Danoff 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mr. Jerome Danoff (Cousin) 2413 Appaloosa Way Finksburg, Maryland 21048 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ott Aug. 11, 2010 (Baltimore Co.) 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. Gardens Timonium, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Jeffrey I. Gair, Sr. Parkani Adjuss of Facilities Funeral & Cremation Center, P.A.

22. Signature of Funeral Service Licensee Jeffrey I. Gair, Sr. Parkani Adjuss of Facilities Funeral & Cremation Center, P.A.

23. Signature of Funeral Service Licensee Jeffrey I. Gair, Sr. Parkani Adjust of Facilities Funeral & Cremation Center, P.A.

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23. Signature of Facilities Funeral & Cremation Center, P.A.

23. Signature of Facilities Funeral & Cremation Center, P.A.

24. Signature of Facilitie 23a. Barth. Interthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) +nysician/ DAYS TO WEEKS RESP Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed plnous 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has page 2 s autopsy perform his certificate h Il director, page Yes ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director; After this completed filled in by the funeral directors. Manner of Death

Natural

Accident Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar 29b. Signature and tit

REGINA

Date filed (Month, Day, Year,

AUG 1 1 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GAN-CARDEN

32. Registrar's Signatur

D61731

29d. Date signed (Month, Day, Year)

2010

8

7601 OSLER DRIVE TOWSON, MARYLAND 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 25088 State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 4, Day 2010 Robert Lee Fields, II 7:55 p . M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Rockville Montgomery Casey House Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) D • C • 8. Date of Birth **Funeral** 1 ¼ M 2 □ F Months Hours Nov. 4, 1961 Director 48 212-84-4554 "natural", or items 23a or 28a-f shov edical Examiner must be notified at death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Silver Spring 1 ☐ Yes 2 No MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 2308 Ecceston St. 20902 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married þ ☐ Yes 2 🛛 No Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rober L. Fields Lillian Rebecca West 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2308 Ecceston St. Silver Spring, MD. 20902 Amy Wilkinson (Pers. Rep.) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crematory Aug. Date 6, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Beltsville, MD. 2010 4 Donation 5 Other (Specify) 22. Name and Address of Facility Rapp Funeral & Cremation Service Funeral Service Licensee M00982 933 Gist Ave. Silver Spring, Maryland 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Pancreatic Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Cause (Disease or in jur) that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ate has been signed by the atte page 2 should be detached for in the past 12 months? Month Pregnant at time of death Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 24 No 1 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 ☐ Yes 2 🕅 No 4 Nursing Home 5 Residence 6 K Other (Specify Hospice IPU ၉ 1 Inpatient 2 ER/Outpatient 3 DOA s after death. 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending 1 Yes 2 No Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated XX Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

,6001 Muncaster Mill Rd. Rockville, MD 20855 Diane Ruckert, CR NP, Registrar's Signa State AUG 1 1 2010 Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

R115108

29d. Date signed (Month, Day, Year) August 5, 2010

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hu

			1 - State Registrar  1. Decedent's Name (First, Middle, Las		-	epartment of F Certificate of I			Reg. N	010	25089
	Physici		Rhoda L.	9	Foe	rster		Month August	Day	2010 Year	8:45 P. M
	/Medic Examin		4a. Facility Name (If not institution, give				Location of Death		4c. (	County of Death	
	Funeral Director		214-40-01/2	744 0775	In yrs. last birtho 93 Yr	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt Month, Da 10/5/19	y Year)	9. Birthp Cour Mary	olace (State or Foreign htry) Land
	ow III		Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Town o	or Location				1	0d. Inside City Limits
	e Mar) ka-fsh liffied	ctor	Maryland Baltimo	re	Arbı	utus					1 □Yes 2 XNo
	23a or 28	ral Dìre	10e. Street and Number 1204 Elm Ridge Ro	ad		10f. Zip Code 212	29			en of What Cour ited Sta	•
0000	be filed within 72 hours after death with the Maryland htal Hygiene. do other than "natural", or items 23a or 28a-f show event, I'm Medical Evan front hust be notified at	d by Funeral Directo	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 Tyes 24 No If Yes, Give Year or Dates:	er in U.S.	13. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 1. No	lispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		4. Race - Americ Black, White, Specify. White	etc.
0000-017	imin 72 h ne. Medical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)		ecedent's Usual Occup Give kind of work done ife. DO NOT use retired	ation during most of work d)	king		nd of Business/In-	dustry
7	e riled within al Hygiene. I other than ' vent, Il	Co	17. Father's Name (First, Middle, Last)		] ]	Homemaker	18. Mother's Nam	o (First Middle		wn Home	
) lall d	ld be T lental rked o	To Be	Frank W. Boyles				Elsi		ford		
ivial y	z snould be z and Menta is marked (raumatic ev		19a. Informant's Name/Relationship (7	ŷpe. Print)	19b. N	Mailing Address (Street	and Number or Ru	ral Route Numb	er, City or	Town, State, Zip	Code)
2,	l and health		Ruth Wisniewski/I	aughter		04 Elm Ridg		rbutus,M		and, 2122	
Daiminie,	permit. Pages 1 and 2 should be Department of Health and Ments Important; if Item 27 is marked any Injury or other traumatic evonce.		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	)	Meadow:	isposition (Name of crematory or other place ridge Memor	ial 8/	9/2010	E1kr	idge,Ma	ryland
Da	Depar Impor any Ir	,	21. Signature of Funeral Service Licens	11/15		22. Name and Addre					Home, Inc.
	hysician	2 1	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	1-	ne death. Do no	t enter the mode of dyir				, ridir y add	Approximate Interval Between Onset and Death
	/Medical xaminer		resulting in death)	Due to (or as a	consequence of)	:					
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease of Injury that initiated events	b. Due to (or as a	consequence of)	:					
,00,00	inicate be executed by physician and as the burial-transit	edical Exa	that initiated events resulting in death) Last	Due to (or as a od.	consequence of)						
.0.	International Action, a feeting rays real, the law requires that the beam countries that the beam countries to the Funeral Director. After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as it	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2→ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	у		2	23d. Date of deliv	ery Day Year
100	n signed build be deta	by	Part II. Other significant conditions co	ontributing to death but	not resulting in the	ne underlying cause giv	en in Part I.				he cause of death?
	icate has bee page 2 shoi	Completed						24a. Was autor perfo 1 ∐Yes		24b. Were auto prior to co death? 1 ∐Yes	opsy findings available impletion of cause of
AILGI	sicilar s certif irector	Be c	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No	Hospital:	0 □ EB/0.+-	Oth	26. Place of Dea				
5	ter this	n: To	27. Manner of Death	28a. Date of Injury (Month, Day,	28b. Tin		y at	28d. Describe		Other (Speci	fy)
VISION	eath. Ior: Af the fur	catio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1 🗆	Yes 2 □No				
	irs after d	Certification:	4 Homicide determined	building, etc.	(Specify)	n, street, factory, office		City or To	wn, State)	)	al Route Number,
	within 24 hours after death.  To the Funeral Director: After completely filled in by the funeral process.	Medical	29a. Certifier  (Check only one)  Check only 2 Medical Exam	/sician: To the best of iner: On the basis of e and manner state	xamination and/	death occurred at the ti or investigation, in my o	me, date and place opinion, death occu	e, and due to the irred at the time,	cause(s) date and	and manner as place, and due t	stated. to the cause(s)
	with vith com	Σ	29b. Signature and title of certifier	6 mp		29c. Licens	e number			e signed (Month,	
	5		30. Name and address of person who co	completed cause of dea	WIM	Callena	Burn	unn		Cunn meno	
	Sta		31. Date filed (Month, Day, Year)	32. Regultrar	s Signature	park				1	
	Registr		AUG 112	Ulu Leur	4 1	garle					

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 2010 **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Overlea Rehabilitation Nursing Home Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In yrs, last birthday) 5. Social Security Number 6. Sex **Funeral** 1□M 2**X**F Months 1, 1943 Maryland Jan. 67 Director 214-40-0970 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County T is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Example must be notified at 1 Yes 2 □ No Director N/A Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number filed within 72 hours after death with USA 21206 4321 Roberton Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Mo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 🛂 No Maryland 21215-0036 Specify. Specify: ģ 3 ₩idowed 4 □ Divorced Black Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 11th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cleo Peoples Charles Dixon ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is n any Injury or other traun once. 4321 Roberton Avenue Baltimore, MD 21206 Kevin Oakley/Son Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 8-10-2010 Glen Burnie,MD Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licenses 4210 Belair Rd. Baltimore, MD 21206 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a con a guence of): Examiner levisto Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) P.O. Box 68760. physician Physician/Medical the for use as attending 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) ☐Yes 2☐No the detached 9 Unknown signed by i 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ¥ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No certificate 1 ☐ Yes 2 🔽 Physician: 26. Place of Death (Check only one) director, 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After this funeral of 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Hospital or Attending Injury Division Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year)
Aligust 7 (\* 2010)

Hd - 21 23 9 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5601 Loch Lack Blvd, Ballimerl Loch 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ GLENN 0210 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 2-7-1935 1 🖫 M 2 🗆 F Months 212-32-7095 Director MD Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21212 USA 1006 Witherspoon Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces þ 1 Never Married 2 X Married 1XXYes 2 ☐ No If Yes, Give Maryland 21215-0036 Black 1 Yes 2 X No 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 hand Mental Hygiene.
7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) U. S Air Force 12th grade <u>Staff Sergeant</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Menl Important: If item 27 is marker any injury or other trainments. Elizabeth Barnes Paul J. Glenn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce E. McLaughlin-Niece 1006 Witherspoon Road Balto, MD 21212 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Removal from State cemetery, crematory or other place) Garrison Forest 8-12-2010 Owings Mills, MD 4 Donation 5 Other (Specify) March East F/H 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 1101 E. North Avenue Balto, MD 21202 1/A 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ NEOPLASM OF BRAIN AND LUNG MALIGNANT disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Examiner Dus to for as a consequence of, Hospital or Attending Physician; The law requires that the death certificate be executed physician and the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ as been signed by the atte 2 should be detached for in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, HYPERTENSION Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? HRONIC RENAL INSUFFICIENCY 24a. Was an autopsy page 2 No 1 Yes 1 Yes 25. Was case referred to medical examiner? **Division of Vital** funeral director, Be 26. Place of Death (Check only one) Hospital 2 No Other: ဂ္ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: Ai completed filled in by the fu Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Gertifying Nume Practioner: To the test of my knowledge, death id at the time, date and plane, and due to the cause(s) and manner as state 29b. Signature and title of certifier MD 1541 1609072495 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREENE ST. BALTIMORE

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar		of Marylan		rtificate of l				Reg. N	Z 11	10	25092
		1. Decedent's Name (First, Middle	, Last)						2. Date of D		) ou	V	3. Time of Death
Physi- /Med		James E. Gri:	ffith						Month Aug.		2010	Year	2:30 P M
Exam		4a. Facility Name (If not institution	, give street and nu	umber)		4b. City, Town, or	r Location o	of Death			c. County	of Death	
		1720 Gillis					ibine				Car	roll	
Funera		, ,	6. Sex 12⊈M 2 ☐ F	7. Age (In yrs. i	last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of E (Month,	Day, Yea	7)	9. Birthp	
Directo	or	214-30-3469 Usual Residence of Decedent		77	115.				Dec.	18,	1932		MD
land ow		10a. State 10b. County		10c. City	y, Town or Lo	cation						1	0d. Inside City Limits
Mary	ţ	MD Car	roll	W	oodbin	e							1 ☐ Yes 2K No
h the	Director	10e. Street and Number		,,,,	OOGDIN	10f. Zip Code				10g. (	Citizen of W	/hat Coun	try?
h witi		1720 Gillis	Road			2179	97				USA		
deat ems	Funeral	11. Marital Status	12. Was Dec	cedent Ever in U.	S. 13.	Was Decedent of H	lispanic Ori	igin? (Spe	ecify Yes or I	No-		e - Americ k, White, e	an Indian,
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shoul Mind Mind	-	19a. Informant's Name/Relationsh			19b. Mailir	ng Address (Street					y or Town,	State, Zip	Code)
nd 2 alth a 27 is		Cindy Bode/	Daughter		1	0 Unionto						•	
permitting is and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. In important: I fleem 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the "Motcal Expriner must be notified at		20a. Method of Disposition		20b. P		sition (Name of natory or other place			ate		Location -		
Page nent c		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		i State		apel Ceme	i	8/10	/2010		Woodb	ine.	MD
mit.	once.	21. Signature of Funeral Service	cent //			urrier-Qu							
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		23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that	caused the death	n. Do not ent	er the mode of dyir	ng, such as	cardiac c	or respiratory	arrest,			Approximate Interval Between
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/Medica	_	resulting in death)		(or as a consequ		ast cance	ST TA						
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To the Hospital or within 24 hours after To the Funeral Director Completely filled in	Certification: To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1	Hospital: 1  28a. Date (Moriania)  graphical (Moriania)  graphysician: To the and mar  who completed cau  y M. D. 8	pointh 2 Feta grant at time of department of the properties of Injury and Day, Year)  The best of my knot basis of examination of the properties of the prop	ER/Outpatier 28b. Time of Injury  welding, death tition and/or in 23a) (Type, House	other (specify)	26. Place eer: 4 New New Year Re? Yes 2 Imme, date a applinion, decise number	e of Death ursing Hol lNo  nd place, ath occurr	24a. Wau au purchase of Check only the 28d. Describe 28f. Location City or and due to the dat the time.	as an topsy one) esidence how in (Street own, St. he cause le, date :	Mo o use control 2 No 24b. \( \) 6 \( \) No 6 \( \) 0th and Numb ate)  and place, Date signed	ribute to the strict of the st	ne cause of death?  pably 4 Unknown  psy findings available mpletion of cause of  2 Mo  (y)  al Route Number,  stated. to the cause(s)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **∆**Month Physician/ 2010 Medical 4c. County of Death Name (if not institution, give street and number) Town, or Location of Death 4b. Examiner andallstown HMOZO 8. Date of Birth Sex . Age (In yrs. last bjrthday) 9. Birthplace (State or Foreign **Funeral** Country) 1 M 2 - F Months Hours Yrs. **Director** March or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No timas 10e. Street and Numbe 10g. Citizen of What Country? 10f. Zip Code ö Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be i Funeral 4128 21133 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black White etc 1 Never Married 2 Married by ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) abled Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည tualson . Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or lene Kanda 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location City or Town, State emetery, crematory or other place) ■ Burial 2 ☐ Cremation 3 ☐ Removal from State lawx 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses Name and Address of Facility ND 2128 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph sician/ PNEUMONIA disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): cate has been signed by the attending physician, page 2 should be detached for use on the bearing. Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be completed filled in by the funeral director, 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) DSTI MID 2010

DHMH 17 Rev 7/2009

State Registrar M.D.

32. Registrar's Signature

1838 GREENE TREE RUAD # 300

PILEGULLE MP 21208

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHARDSON

LEONARD

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 25094 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Elsie Ruth Hoch 3:00 A. M August 08,2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Edenwald Retirement Community Baltimore County Towson Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

April 28,1925

Baltimore, MD. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days **Funeral** Months Hours 1 □ M 2 ★F 213-20-7614 85 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show r than "natural", or Items 23a or 28a-f shov It e Modical Examiner is ust be notified at 1 ☐ Yes 2X No Maryland Baltimore County Towson Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21286 800 Southerly Road United States Apt. 902 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. hours after 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Maryland 21215-0036 White <u>^</u> 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Office Secretary 12 02 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ould be f Mental I Ruth LeCompte Wallace Roy Atwell Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) f Health item 27 i Nottingham, Maryland 21236 Mrs. Dorothy T. Rau (Sister) 8605 Silver Meadow Lane Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Aug. 10, 2010 (Baltimore Co.) 20a Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. Gardens Department of Importent: If any injury or once. Timonium, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Ligensee Jeffrey L. Gair, Sr. Paceful Alternatives Funeral & Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093-2215 gar, K. Lic. #100677 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lint only one cause on each line. Approximate Interval Between Onset and Death Advanced Alzheiner's type dementia Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine requires that the death certificate be executed burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 Yo
9 Unknown 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Manner of Death 28b. Time of After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation Accident after death Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à 4 - Homicide Hospital or within 24 hours a To the Funeral 6 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) the 0

Registrar

DHMH 17 Rev 1/2001

State

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

JSchen

R 154032

800 Southerly Rd Towson MD 21286

10-05763	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

David Allen Hamil	1	I- For State	State	of Marylaı		partment Pertificate			d Menta	i Hyg		Reg. No	201	0	2509
Physiciar	1/	Registrar 1. Decedent's Name (First, Mi	ddle,Las	t)							Date of De	eath		Т	3. Time of Death
Medical Examin		David Al			lton	1					Month August 1				0012 hrs
		4a. Facility Name (if not institute for the facility Name) (if not institut	, 0	e street and num	nber)			ty, Town, or I ddle River		Death			tc. County of Baltimore		ntv
Funeral	4	Social Security Number	6. Se	x 7	7. Age (In y	rs. last birthday		Jnder 1 Year		24Hrs.	3. Date of B				place (State or
Director		217.68.3129	117	M 2 F		55	Yrs. M	onths Days	Hours	Min.	11,2	0.1	954	oreign Cou	ntry) MD
	ŀ	Usual Residence of Decedent		<u> </u>											
* any	ſ	10a. State 10b. Cour	•		10c. (	City, Town or Lo	ocation								10d. Inside City Limits
land f shov	١		tim	ore	Mi	ddle 1									1 Yes 2 No
Mary r 28a-	Director	10e. Street and Number					10f	Zip Code					itizen of Wha	t Count	ry?
th the notifi		601 Sopwith	Dr	. Apt.		-116 142	Was Da	212 cedent of Hisp		2 / 8=50	f. Van ar N		.S.A.	Amaria	an Indian, Black,
ath w items	uneral		Married	Armed For	ces?			ecify Cuban,				NO-	White,	etc.	
ffer d	<u>"  </u>	3 Widowed 4	Sivorced	1 Yes	2 N	0 1	Yes	2 No	specify:				Specify.h	ite	
ours a	<u>a</u>	15. Decedent's Education (S	pecify or					sual Occupation				16b.	. Kind of Busi	ness/In	dustry
36 n 72 h nan "r ical E	ompleted	Elementary/Secondary (0-1	2)	College (1-	4 or 5+)		-	working me.	00 110 1 40	0 100100	,		_		
Within within ther the	<u>E</u>	17. Father's Name (First, Midd	le Last)	_		u u	nk	1	18.Mother's I	Name (Fi	irst Middle		Gover	nme	nt
215. Red of the filed mt, th	ည Re			lton					Mary				,		
213 ould b d Men s mar lic eve		19a. Informant's Name/Relation					-	ress (Street	and Numbe	er or Rura	al Route N	umber, (	City or Town,		
MD d 2 sh lth an n 27 is	L	Beverly Han	ilt	on/Ex-								/il:	le, M	D 2	1234
ore, slan of Hea If ite		20a. Method of Disposition  1 Burial 2 Cremate	ion 3	Removal from	m State	Ob. Place of Dis	or other pl	ace)		_	ate	- 1	: Location - C		
imo Page ment tant:	L	4 Donation 5 Other	Specify:			Chesar									e, MD
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21 Signature of Funeral Serv	ce Licen	see 1	4014	43 2	22. Name	and Address	of Facility (	CAF	A/Ste	ephe	en D.	Lo	hrmann, P
Physician	+	23a. Part I. Enter the disease,	or comp	lications that cau	used the de	(	<i>3 / l /</i>	Gree	n Pa	<u>s t u i</u>	res L	Jr.	Balto	2	MD Approximate Interval
/Medical		failure, List only one cau		ch line. <b>Athero</b> sc <b>ler</b> c	tic Card	iovascular l	Disease	4						- 1	Between Onset and Death
Examiner		Immediate Cause (Final disea or condition resulting in death	-	Due to (or as a c			<b>D</b> 100401							$\neg$	
	_	Sequentially list conditions,	b.	Due to (or as a c										-	42
		if any, leading to immediate cause. Enter Underlying Cau (Disease or injury that initiate	10	Due to (or as a c	Misequeik	e or):									
red sait		events resulting in death) Las		Due to (or as a c	consequenc	ce of):									
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60, ate be a	<b>⊕</b> ⊢	IF FEMALE:		23c. If yes, ou	utcome of p	regnancy						1 2:	3d. Date of de	elivery	
Box 68760  e death certificate the attending physical for use as the bu		23b. Was decedent pregnant in past 12 months?	the	1 Live bir	th	2	Fetal de	ath 3	Ectopic p	regnancy	,	-	Month	Da	y Year
SOX leath of attention for use	3	1 Yes 2 No 9	Inknown	9 Unknov	nt at time o vn	f death 5	Other (	Specify)				- 23			
F.O. Baires that the designed by the		Part II. Other significant con	ditions	contributing to		ot resulting in t	the under	ying cause gi	iven in Part	1.	23e. Did	tobacco	o use contribu	ite to th	ne cause of death?
Division of Vital Records, P.O. ra after death.  Taler death.  Tal Division of Vital Records, P.O. or after death.  Tal Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.		Diabetes								_	1Y	es 2[	No 3	Proba	bly 4 🗸 Unknown
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tal Rection: The certificate ector, page	اه	25. Was case referred to med	cal	-		-		26 Place	of Death (CI	heck only					
Vit	9	examiner?  1  Yes 2 No	- ПН	ospital: 1 In	patient 2			DOA	Other <sub>4</sub> N	lursing H	iome 5	Resid	dence 6 🗸	Other:	Scene
Division of Vital I our site of Vital I our steeding Physician: our steed eath. Her this certification by the funeral director.		27. Manner of Death  1 ✓ Natural 5 Periods		28a. Date of (Month, I	f Injury Day,Year)	28b. Time	of Injury		y at Work?		d. Describ	e how ir	njury occurred	!	
Siol Atten r death ector: by the	ertification:		ending vestigation		of Injune /	t home form	atract for		es 2 N		f Location	(Stroot	and Number	or Dur	al Route Number, City
Divi		de	ould not be termined	oe	or injury - A	At home, farm,	sir <del>ee</del> i, iac	tory, onice bu	uliaing, etc.	120	or Town,		and Number	or Rura	al Route Number, City
Division the Hospital or Attent hin 24 hours after deatt her Funeral Director: npletely filled in by the	ント	20a Cartifier	Physici	an: To the best	of my know	riedge, death o	ccurred a	the time, dat	te and place	and du	e to the ca	use(s) a	and manner a	s stated	
Division of Vital Records, P.O. Box 6876( To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the beautiful or the funeral director.				On the basis of and manner sta	examinatio										
F ≯ F g	ž	29b. Signature and title of cert	ifier	1		/,		29c. License					. Date signed		h, Day, Year)
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80.1		30. Name and address of pers Jack Titus MD. D		ompleted cause Chief Medica			Denn C	treet, Balti	imore MI	2120	11				
<b>₩</b> ₩	to	31. Date filed (Month, Day, Yea			istrar's Sigr		eiii S	meet, Daill	iiiioie, IVII	J Z 1 Z L	, I				
Stat Registra	~	AUG 1 1 20	ÍA	A		1-									

ORIGINAL

			1 - State of Registrar	•	rtment of Health and N <i>tificate of Death</i>		ene j. No. 2010	25096
	n		Decedent's Name (First, Middle, Last)			Date of Death     Month	Day Year	3. Time of Death
	Physicia /Medic		Edward William	Howard, Sr		August 0	7, 2010	6:00 A. M
	Examin		4a. Facility Name (If not institution, give street and num		4b. City, Town, or Location of Death		4c. County of Death	
- ·				Fusting Ave	Catonsville If Under 1 Year   If Under 24 Hrs.	9 Date of Pirth	Baltimore	e holace (State or Foreign
	Funeral Director		219-03-3602	. Age (In yrs. last birthday) 89 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, ) 02-22-19	(ear) S. Bill Co.	hplace (State or Foreign untry) Maryland
	aryland show	r	Usual Residence of Decedent  10a. State  10b. County	10c. City, Town or Loc		D 1		10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	he Ma	Director	MD Anne Arundel		Severn  10f. Zip Code	a Park	. Citizen of What Co	
	with the last or 2	Dir	10e. Street and Number 257 Berrywood Drive		21146	100	United S	
	ns 23	Funeral	11 Marital Status 12. Was Deced	ent Ever in U.S. 13. V	Vas Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	rican Indian,
326	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the in-dical Evention.	by	Armed Force  1 Never Married 2 Married 1 Yes 2  If Yes, Give Year or Dal	<b>X</b> [_XNo 1	Yes, specify Cuban, Mexican, Puerto  ☐Yes 2 XX Xo Specify:	Hican, etc.)	Specify: Wh	e, etc. Lite
15-0036	in 72 hou n "natura	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give I	ent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing 16	6b. Kind of Business/	Industry
7.17	s with	lmo	Elementary/Secondary (0-12) College (1-4		Logistics		Dairy	
פ	al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Nam	e (First, Middle, Ma	uiden Surname)	
<u> </u>	2 should be and Mental is marked o	To E	Samuel Price Howard		Edna F1	agle		
Maryland	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type. Print)		g Address (Street and Number or Ru			
	permit. Pages 1 and 2 Department of Health s Important: If item 27 is any injury or other tra once.		Edward Howard, Jr son 20a. Method of Disposition	20b. Place of Dispos cemetery, crem	errywood Drive, S		Oc. Location - City or	
<u></u>	ages ent of it: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from S 4 ☐ Donation 5 ☐ Other (Specify)	are	ge Mem. Prk. 08-1	0-2010	Elkridge.	Maryland
Baltimore,	nit. F vartme ortan injur		21. Signature of Funeral Service Licensee		Name and Address of Facility Gar			
ñ	Der Imp		23a. Part 1. Unter the disease, or complications that ca	me MM	P., Inc.,7250 Was	h Blvd.,	Elkridge,	
			shock, or heart failure. List only one cause on ea	ch line.			,	Interval Between Onset and Death
and a	Physician /Medical		disease or condition a.	r as a consequence of):	scular Deme	WY		four
and the second	Examiner		Due to (c	as a consequence on.				,
	. ⊅ ±	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	r as a consequence of):				
	ecute and -transi	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (c	r as a consequence of):				
8/60,	certificate be executed adding physician and se as the burial-transit	edical E	d	as a consequence or,				
0	ertifica ling pl		IF FEMALE:					
C. Box	eath atter for u	Physician/M	in the past 12 months?  1 Live bi	ant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of del Month	livery Day Year
<u>۲</u>	that the led by th detache	Phy	9 ☐ Unknown  Part II. Other significant conditions contributing to dea	ath but not resulting in the ur	derlying cause given in Part I	23e. Did toba	acco use contribute to	o the cause of death?
Hecords,	e law requires that the dhas been signed by the le 2 should be detached	d by	Tartin. Other significant conditions continuing to dea	arr but not resulting in the di	noonying cause given in rainti.			robably 4 Unknown
<del>ပြ</del>	law rec as bee 2 shou	Completed				24a. Was an	24b. Were at	utopsy findings available
	The la ate ha page 2	omp				autopsy perform 1 🗆 Yes 2	ed?   death?	completion of cause of 2 □No
VITal	ian: rtifica stor, p	Be C	25. Was case referred to medical		26. Place of Dear	th (Check only one		
<u> </u>	Physician: r this certific ral director, <sub>I</sub>	To E	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Ir	patient 2 ER/Outpatien	t 3 DOA Other: 4 Nursing H	ome 5 🗆 Resider	nce 6 Other (Spe	ecify)
ono	nding Physician: The I tth. :: After this certificate h e funeral director, page	ation:	27. Manner of Death  1. ♣Natural 5 Pending (Montile 2 Accident investigation	f Injury 28b. Time of Injury Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe hov	v injury occurred	
DIVISION	To the Hospital or Attending P within 24 hours after death.  To the Funeral Director: After t completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined 28e. Place of buildin	of Injury - At home, farm, streng, etc. (Specify)	eet, factory, office	28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,
	Hospita 4 hours Funeral ely fillec	edical C	(Check only 2 Medical Examiner: On the ba	sis of examination and/or in	n occurred at the time, date and place vestigation, in my opinion, death occu			
	thin 2 the mple	Med	one) and mann 29b. Signature and title of certifier	er stated.	29c, License number	29	d. Date signed (Moni	th. Dav. Year)
	F 3 F 8				737573	•	Aurust c	1,7010
	21		30. Name and address of person who completed cause		Print) A	12-17.	some la	7 21700
	Sta	te		gistrar's Signature	July hoe	154111	700	- 0,007
	Registr		AUG 1 1 2010	. S. S.	21			
DHI	MH 17 Rev 1/2	001	100 1 1 2010 /20					
				ORIG	INAL,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death **Physician** 1831 2010 /Medical acility Name (If not institution give street and number. City, Town, or Location of Death 4c. County of Death Examiner timore Date of Birth (Month, Day, Year 149 26 1 Numbe . Age (In yrs. last birthday) 9. Birthplace (State or Foreign County) **Funeral** Min. Months Hours 1 □ M 2 🗷 F Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Expresser must be notified at Director 1 XYes 2 ☐ No Iontaomer 10e. Street and Number 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ☐ Yes 2 M If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 **N**No Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify ģ. 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be i lealth and Mental 2 arson Health and N 19a. Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Columbia ackson(Dayahlor)11700 Deprena C 20a. Method of Disposition injury or other permit. Pages 1 an Department of Heal Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) lwings Mil 21. Signature of Funeral Service Licensee 21229 Bathmore 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) certificate be executed 200 and burial-tra Due to (o as a consequence of): Box 68760. attending physician Physician/Medical the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 힏 in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 5 Other (specify) ned by the a P.0. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Monknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has was and autopsy performed?
Yes 2 No page 2 certificate 1 ☐ Yes 2 🗆 No Division of Vital 1 TYes Hospital or Attending Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 **N**0 2 ER/Outpatient 3 DOA Certification: To After this funeral Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident investigation filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MD 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

AUG 1 1 2010

Berke

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

helle Kosmid	ki		f Maryland / Dep	artmen						2010	25099	
		1- For State Registrar	g. No.									
Physici dical Exami		III CIICII C	ee	Ko	smicki		1 -	Date of Death Month August 9, 2	Day	Year	3. Time of Death 0224 hrs	
		4a. Facility Name (if not institution, give st 2008 Larkhall Road	treet and number)		4b. City, Tow Dundalk	n, or Location o	of Death			County of Death altimore Cou		
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthda	y) If Under 1	Year If Under	r 24Hrs. 8	. Date of Birth	h(MM/DI		hplace (State or	
Director			2 <b>X</b> F 27		Yrs. Months	Days Hours	Min.	NOV.5,	1982	Poreig Cor	n untry) MD	
any		Usual Residence of Decedent  10a. State 10b. County	Inc. Cit	y, Town or L	ocation						10d. Inside City Limits	
<b>*</b> .		Maryland Baltimore		ndalk							1 Yes 2 X No	
aryland Sa-f sh	ctol	10e. Street and Number	<sub>j</sub> Du	HUAIK	10f. Zip Co	de		10	g. Citize	n of What Cour	ntry?	
ith the Maryland 23a or 28a-f show	Director	2008 Larkhall Road			212	22			Ι	J.S.A.		
with ns 23, be not		11. Marital Status	2. Was Decedent Ever in I	J.S. 13	s. Was Decedent of	of Hispanic Origi			can Indian, Black,			
or ite	Funeral		Armed Forces?  Yes 2 X No		If Yes, specify C		Pueno Ric	an, etc.)	White, etc.			
s after rral", niner	by		Dates:		Yes 2X edent's Usual Doo		and of work	dona	ite			
2 hour "natu	ted	15. Decedent's Education (Specify only I Elementary/Secondary (0-12)	College (1-4 or 5+)		ng most of working				nd of Business/I	ndustry		
D36 thin 7, ne.	Completed	12	, , , , ,	Bar	tender				Re	estaura	nt	
215-0036 be filed within 7 atal Hygiene. rked other than ent, the Medica	Cor	17. Father's Name (First, Middle, Last)						rst, Middle, M	laiden St	urname)	<del></del>	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Be	Michael Leroy Ko		Mary  19b. Mailing Address (Street and Number or						Rile		
D 21 should band Mer 7 is mar	ြ	19a. Informant's Name/Relationship (Type	•	110	ailing Address ( $31$ $E1ton$				-		•	
and 2 sho lealth and tem 27 is traumati		Mary Riley (mothe 20a. Method of Disposition	20b.	Place of Di	isposition (Name o					cation - City or		
Baltimore, permit. Pages 1 a Department of He Important: If ite		1 Burial 2 X Cremation 3	Removal from State	-	or other place) c Cremat	0237	ΩR /11	/10	G1 or	a Rurni	a Marvland	
ltir nit. Pa artmer ortan		4 Donation 5 Other Specify:  21. Signature of Fusion Service Licensee						8/11/10   Glen Burnie, Mary er & Son, Inc.				
B Per de di inju	1	11/1/1/20	prosey		6224 Ea	s. Zei stern A	ve, B	Son, altimo	re,	Maryla	nd 21224	
Physician		23a. Part I. Enter the disease, or complica failure. List only one cause on each	tions that caused the deat	h. Do not er	iter the mode of dy	ving, such as ca	rdiac or res	spiratory arre	st, shock	k, or heart	Approximate Interval Between Onset and	
/Mic_I Examiner			ultiple Injuries								Death	
		h	e to (or as a consequence	of):								
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executed an and al - transit		d.										
	an/Medical	UNPENDED A	MENDED									
760 ficate b	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pre		1 =	2 DEstanta				Date of delivery	Your Voor	
Box 68760 e death certificate b the attending physi	ciar	past 12 months?	4 Pregnant at time of d	eath 5	Fetal death Other (Specify)	3 Ectopic	pregnancy		1	lonth D	ay Year	
Bo deat the at the at	Phys		9 Unknown									
P.O. es that the igned by be detach	by P	Part II. Other significant conditions co	ntributing to death but not	resulting in	the underlying cau	ise given in Par	t I.	_	_	e contribute to	the cause of death? ably 4 Unknown	
ords, P.C v requires that s been signed b should be deta	sted						_	24a. Was ai			opsy findings available	
Records, The law require ficate has been si , page 2 should b	ompleted							autops perforn	ned?	death?	ompletion of cause of	
Re ifficate or, pag	ပ	25. Was case referred to medical			26 P	lace of Death (	Chack only	1 Yes 2	No No	1 <b>✓</b> Ye	s 2 No	
/ital	e Be		oital: 1 Inpatient 2	ER/Outpa		Othor:	Nursing He		Residenc	e 6 🗸 Other	Scene	
of Vital Reco		27. Manner of Death	28a. Date of Injury	28b. Time	of Injury 28c.	Injury at Work?		l. Describe ho				
ision Attendir r death. rector: A by the fu	ication	1 Natural 5 Pending 2 Accident Investigation	Aug 9, 2010	0213 hr	S 1	Yes 2		ver or ven I was ejec		nich struck p	oole, overturned	
Division of Vital ral or Attending Physician: ra after death.  "al Director: After this certii led in by the funeral director.	ertific	3 Suicide 6 Could not be	28e. Place of Injury - At h		street, factory, offi	ce building, etc		or Town, Sta	ate)		al Route Number, City	
Divi	0	4 Homicide determined  29a. Certifier A Cartifier Physician	(Specify) Local Stre							Ashwood Rd,		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	edical	one) 2 Medical Examiner: Or	To the best of my knowled the basis of examination and manner stated.									
Z 2 2 8	Me	29b, Signature and title of certifier	29c. Lic	29c. License number 29d. Date signed (Month, Da				th, Day, Year)				
	O.C.M.E. August 9,								st 9, 2010			
11	İ	30. Name and address of person who completed cause of death (Item 23a)  Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201										
l v		Patricia Aronica-Pollak MD.  31. Date filed (Month, Day, Year)	Assistant Medical  32. Figistrar's Signat		IIIPenn	otreet, Bal	umore, r	VID 2 [20]				
31	ate		J. J									

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20a\_cstate of War Han 6906e 84 177 22010 Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 Dannie Lee Lollar August 8:40 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 8228 Autum Lake Court Severn Anne Arundel 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Age (In yrs. last birthday) Days (Month, Day, Ye Country)
West Virginia 1 ☑ M 2 □ F Min. Director 232-78-0052 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if fiem 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examinar must han material. 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location **Funeral Director** Anne Arundel Severn 1 Yes 2 X No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8228 Autum Lake Court 21144 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 Specify: black 1 ☐ Yes 2 ☑ No Specify 3 ☐ Widowed 4 🖾 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) unk unk driver United States Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk ပ္ Noble Lollar 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dana Lollar - daughter <u>Hyattsville, Maryland 2078</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 8/19/2010 Chesapeake Crem. Beltsville, MD. omy Boare CAFA/S, LOHRMAN 22. Name and Address of Facility Sign It & of Funeral Schvice Licer of de, W. Baltimore Stree Creen Pastures DR Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Oriset and Death Immediate Cause (Final disease or condition Physician/ myocardial Medical resulting in death) Due t (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last arterioscleratio Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 XVes 2 □ No 3 □ Probably 4 □ Unknown within 24 hours after death.

To the Funeral Director, After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 N sterolemia 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 📈 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 027513

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

AUG 1

Ind address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

**Funeral** 1 □ M 2 🖾 F 72 218-34-1746 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic avant 10a. State 10b. County 10c. City, Town or Location MD Cecil Perryville Funeral Director 10e. Street and Number 10f. Zip Code 21903 580 Aiken Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Be Completed by Yes. Give 3 Widowed 4 Divorced Year or Dates (Give kind of work done during most of working life. DO NOT use retired) 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Everett Janney Eklund 2 19a. Informant's Name/Relationship (Type. Print) Williard R. Lee - husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee 1 222 Immedia Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a conse dence of): Examiner Sequentially list conditions, if any, leading to immediate any first any leading to immediate any first and the sequence of th Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) P.O. Box 68760. attending physiciar Physician/Medical as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ Be Completed 24a. Was an has 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? Other: 4 \( \sum \) Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA this Manner of Ceath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Injury 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a

To the Funeral D

1. Decedent's Name (First, Middle, Last)

580 Aiken Avenue

4a. Facility Name (If not institution, give street and number)

Myrtle Lee

Physician

/Medical

Examiner

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Dec 15, Social Security Number Birthplace (State or Foreign 7. Age (In yrs. last birthday) ″1°937 Maryland 10d. Inside City Limits 1 ☐ Yes 2 No 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry un 18. Mother's Name (First, Middle, Maiden Surname) Hattie Ann Fuller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 580 Aiken Avenue; Perryville, Maryland 21903 20c. Location - City or Town, State 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street; Baltimore, MD 21201 3a. Pa 1. Enter the discusse, or somplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23d. Date of delivery Year Month Dav 23e. Did tobacco use contribute to the cause of death? 2 🗌 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performe Yes 2 Residence 6 □ Other (Specify) Medical Certification: To 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation in my opinion, death account at the cause(s) and manner as stated 29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of D66912 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 602 S. Atwood RD S Venkata Krishna Parsa Md Oncology Associates Bel Air, Md. 21014 32. Registrar's Signature AUG 1 31. Date filed. State Registrar

amend #30 Per DVR G906 8/11/2010 JH State of Maryland / Department of Health and Mental Hygiene 0 10

Certificate of Death

4b. City, Town, or Location of Death

Perryville

2. Date of Death

August

Month

3. Time of Death

12:15 PM

2010

4c. County of Death

Cecil

10-05935 Jeffrey Lawson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Jenrey Lawson	1- For State Registrar  Certificate of Death Reg. No. 20 10 25 10	)2
Physician/ Medical Examine		
	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or	
Director	215-78-7921 1X M 2 F 46 Yrs. Months Days Hours Min. March 19, 1964 Foreign Portsmout	th,
any	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City L	
yland tonce.	MD Harford Forest Hill 1 Yes 2 \( \subseteq \) 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	ζNο
the Maryland is or 28a-f sh	232 Aster Lane 21050 U.S.A.	
er death with t	11. Marital Status  12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  White, etc.	
s after de rral", or niner mi	or Dates:	
n "natural Exam	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of 8usiness/Industry  16b. Kind of 8usiness/Industry  16c. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16c. Decedent's Layer	
5-0036 led within 72 hour tygiene. other than "natu the Medical Exan Completed	10 BTTCN Bdy CT  17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname)	
1215. The filed ental Hy urked of vent, the	Jimmy Lee Lawson Haley Griffey	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
ore, I and of Healt If item	20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  Bel Air Memorial  20c. Location - City or Town, State  Bel Air, Maryland	
ultiment. Pagartment sortant:	Donation 5   Other Specify:   Gargens   2010	
	21. Rignature of Funeral Service Licensee  22. Name and Address of Facility 23. Name and Address of Facility 24. Name and Address of Facility 25. Name and Address of Facility 26. Name and Address of Facility 27. Name and Address of Facility 28. Name and Address of Facility 28. Name and Address of Facility 29. Name and Address of	onvol
Physician /Medical Examiner	failure. List only one cause on each line.  Immediate Cause (Final disease a. Hanging	
LXammer	Or condition resulting in death)  Due to (or as a consequence of):	
niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause c.	
). Box 68760, the death certificate be executed by the attending physician and ched for use as the burial - transit Physician/Medical Examiner	(Liseass or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.	
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Box 687 e death certifica the attending p ed for use as th	4	
P.O.	1 Yes 2 ✓ No 3 Probably 4 Unkno	
Records, The law requires ficate has been sig	24a. Was an autopsy findings avai	
Reco The law icate has page 2 s	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No	
Vital Recystian: The his certificate director, page	25. Was case referred to medical  examiner?  Uhospital:   Other    Other   Other    Other    Other    Other    Other    Other    Other    Other    Oth	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the radic death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach ertification: To Be Completed by P	77 Monor of Death 290 Date of Injury 290 Time of Injury 200 January Media 201 Describe how injury appropria	
Division o spital or Attending nours after death fineral Director: Aft meri filled in by the fune Certification:	Accident Investigation    Accident   Accident   Suicide   Could not be	City
Division spital or Attent hours after death meral Director: y filled in by the Certificatic		КD ) )14
To the Hos within 24 h To the Fur completely	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  One)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
F 3 F 3	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29c. License number 29d. Date signed (Month, Day, Year) 40c. M.E. 40c. August 9, 2010	
	30. Name and address of person who completed cause of death (Item 23a)	
Contra	Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  31. Date filed (Month, Day, Year) 32. Registrar's Signature	
State Registrar	LILO A A DOLO BI	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 25 per me 2914 4-7-11 vt. State of Maryland 7 Department of Health and Mental Hygiene 0 10 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ Lindamood 1605 PM 2010 August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE JOHNS HOPKING BAYVIEW MEDICAL CENTER 8. Date of Birth
(Month, Day, Year)
Tun 30, 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days 1 🗆 M 2 💢 Months Hours Min. Country) 58 1952 MD Director 212-58-4334 Usual Residence of Decedent shov 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State filed within 72 hours after death with the Maryland Director ral", or items 23a or 28a-f s' Examiner must be notified 1 ☐ Yes 2 🗷 No Sparrows Point Baltimore 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? Funeral United States 21219 2520 S. Snyder Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces? Black White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: "natural" Completed 3 Widowed 4 Divorced White Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hospitality 9 Waitress item 27 is marked other other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ should be t Catherine Ann Timerman Robert Bailev t. Page 1 and 2 shou tment of Health and tant: If item 27 is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dexter Dobbins /Son 520 Callander Way Abingdon, MD 21009 permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other 1 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Aug 11 Beltsville, Maryland 4 Donation 5 Other (Specify) 2010 Chesapeake Crematory 21. Signature of Funeral Service Licensee 22. Nameral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician/ Severe sepsic **Medical** resulting in death) Due to (or as a consequence of) Examiner irkosis Sequentially list conditions, if any, leading to immediate Examine OX APPROVIOUS MESICAL EXAMINER hepaths C virus Cause (Disease or iinjury that initiated events and the burial-tran Due to (or as a consequence of): resulting in death) Last CERTIFICA physician Physician/Medical Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) for in the past 12 months? Dav Year Month Pregnant at time of death Unknown signed by the a Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗡 Unknown Completed 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has page nerformad' 1 ☐ Yes 2 X No 1 Yes 2 No 25. Was case referred to medical examiner?

1 🖾 Yes funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital Inpatient 2 ER/Outpatient 3 DOA မ After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending injury work? Natural 5 Pending after death. 1 Yes 2 🗌 No Accident Investigation the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filler in by 4 🗌 Homicide determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29b. Signature and title of certifie RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Bastern Avenue Baltimore, MD, 21224 Parsons MD 32. Registrar's Signature State Registrar

"Elizabeth F Morten" Patient known as

			Please amend #19a	Type or Pri	nt in Black II 7/10JH aryland / Depa	ndelible Ink	Ensure	All Copie	es Are Legible	0.510.1
			For State Registrar	Otato of IVI	Certificate of Death			Reg. No.		
	Physicia	ın/	1. Decedent's Name (First, Middle, La.	· .				2. Date of De Month	Day Year	
	Medic Examin	cal	Elizabeth Mc 4a. Facility Name (if not institution, give	-	4b. City, Town, or Location of Death			August 07 2010 04:43 A M		
	^	ICI	Sinai Hospital	none				N/A		
	Funeral Director			3-32-9031 1□MX☑F 77 Yrs. Months Days Hours Min. (Month, Day, Year) Co						irthplace (State or Foreign ountry) rginia
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if flem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	10a. State 10b. County		10c. City, Town or Location					10d. Inside City Limits
			Maryland		Baltimore					1 🔀 Yes 2 □ No
			10e. Street and Number 10f. Zip Code 21207 10g. Citizen of What Country?					Country?		
Baltimore, Maryland 21215-0036			11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1  Yes 2 If Yes, Give Year or Dates.	(No	Was Decedent of His If Yes, specify Cuban, 1 ☐ Yes 2 ☑ No	Mexican, Puerto	ecify Yes or No Rican, etc.)	14. Race - Arr Black, Wh Specify: Bl	ite, etc.
			(Specify only highest gr Elementary/Seconday (0-12)	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  2th grade  Nurses Aide			ring most of wor	of working BonSecours Hospital		
		Be	12th grade  17. Father's Name (First, Middle, Last) Archie Wynn							
Mary			19a. Informant's Name/Relationship (1 Morten Angela Norton/	Type, Print) Granddaı	ıghter 29	ng Address (Street an 02 Wynha	nd Number or Ru m Road	ral Route Numb Balti	er, City or Town, State, 2 More, Mary	Cip Code) Land 21216
imore,			20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci		20b. Place of Dispo cemetery, crer Baltimor	natory or other place,	8/1 al Cem	3 <sup>at</sup> 10	20c. Location - City of Baltimore	or Town, State e, Maryland
Balt			21. Signature of Funeral Service Licen	Loses	5	2. Name and Address 240 Reis	of Facility Ch tersto	atman- wn Rd	Harris Fu Baltimore	neralHome ,MD 21215
	Physician/		23a. Part 1. Enter the disease, or com shock, or heart failure. List only o Immediate Cause (Final	one cause on each line	е.	er the mode of dying,	such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)	a. Pneumonia Due to (or as a consequence of): Sensis						2 days
-	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	D	Due to (or as a consequence of):					
Q Q			Cause (Disease or injury that initiated events resulting in death) Last	c						
. Box 68760			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1  Live Birth 4  Pregnant a	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	lelivery Day Year
s, P.O.		þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Chronic Obstructive Pulmonary Disease  1   Yes 2   No 3   Probably 4   Unknown							
Record		Completed	Hypertension 24a. Was an autopsy performed? death?				utopsy findings available completion of cause of			
ta 		Be	25. Was case referred to medical 26. Place of Death (Check only one)							
<u> </u>		e: To	2 1 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Speci						ecify)	
Division of Vital Records,		Medical Certificate:	1 Matural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	(Month, Day, Year) injury work?  Injury work?  I □ Yes 2 □ No				non injury occurred		
					ury - At home, farm, str c. (Specify)	eet, factory, office			(Street and Number or R wn, State)	ural Route Number,
_			29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	To the within the company of the com		≥9b. Signature and title of certifier  Namula Syd , MBBS			29c. License number RES - 000			29d. Date signed (Month, Day, Year) August, 07, 2010	
			30. Name and address of person who NAMITA SINCH	completed cause of d	eath (Item 23a) (Type, F	Print) HOSPITAL	. 000	ALTIMO	RE	
	Stat		31. Date filed (Month, Day, Year)		ar's Signature	Care II	_ 0: 1	101111		
DHM	Registra	-	AUG 112	NU Down	u B. A					

Please Type or Print in Black Indelible Ink. Ensure Ail Copies Are Legible.
amend #18819a Per FH G906 8/19/2010 JH
State of Maryland / Department of Health and Mental Hygiene 2 0 1 0 State State 8/24 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MURPHY Dayth Physician/ EDWARD Month 6:45 PM August 2010 Medical 4a. Facility Name (if not institution, give street and number)

CARROLL HOSPITAL CEN
200, Memoria Examiner 4b. City, Town, or Location of Death 4c. County of Death Westminster MD CARROLL Avenue 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1**X** X M 2 □ F Hours 3/24/1943 67 Mary land 215-40-1013 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Mount Airy Maryland Carrol1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2800 Gillis Rd. 21771 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. should be filed within 72 hours after d and Mental Hygiene. is marked other than "natural", or i 1 Never Married 2 Married Completed by Yes 1 ☐ Yes 2XXX No Specify: If Yes. Give Specify: White 3 Widowed 4XX Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours popartment of health and Mental Hygiene. Important If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16h Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Self-Employed Construction 18. Mother's Name (First, Middle, Malden Suprame) Thomas Esther Nemethwargo Be 17. Father's Name (First, Middle, Last) ည Murray Edwin Murphy 1 A Romant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <del>erry</del> Houp (Daughter) 6510 Bonnie Brae Rd. Sykesville, Md 21784 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Lake View Memorial Park 8/10/2010 Sykesville, MD Burrier-Oueen Funeral Home and Crematory, P.A. 1212 W. Old Liberty Rd. Winfield, Md 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition CONGESTIVE HEART Medical resulting in death) Due to (or as a consequence of) Examiner ATHEROSCLEROTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death Day 2 No 1 Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 No 1 🗌 Yes 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes ျှ 1 npatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier D0063564 August 5th 2010 , 200 Memorial Avenue, Westminster, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kalpesh Patel Cavroll Hospital Cower 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

Records,

**Division of Vital** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ 18:20 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Point 4 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under **Funeral** July 16, Year 936 1 🖾 M 2 🗆 F Min. Days Mary land 213-34-0862 74 Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location the Maryland Director MD Harford Bel Air 1 ☐ Yes 2 🏝 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number by Funeral USA 21015 1508 Westview Court 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1957 1 ☑ Yes If Yes, Give 1 Never Married 2 K Married 2 🗌 No Specify: White 72 hours after 1 ☐ Yes 2 🛣 No 3 Widowed 4 Divorced 1960 Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 12 sales is marked other Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Balbina Amelia Siewierski 2 Charles Bartholomew Miller Sr. permit. Page 1 and 2 should be 1 Department of Health and Ments Important: If item 27 is marked any injury or other traumatic en 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1508 Westview Court; Bel Air, Maryland 21015 Elizabeth J. Miller - wife Baltimore, 20b. Place of Disposition (Name of 20a Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 🛛 Donation 5 🗍 Other (Specify) Signature of Funeral Service Licensee Ronald Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. System the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death LLO BEDSTUNA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of, within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 No 1 Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 2 No မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Hospital Medical

State Registrar 29a. Certifier

(Check

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

AUG 1

completed cause of death (Item 23a) (Type, Print) 11 mar

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number

DASTONE

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 16b per fb e906 8-11-10 vt State of Maryland / Department of Health and Mental Hygien 0 1 0 1 - For State Registrar Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) August Larry Don Martin 2010 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1-26-1948 Security Number D . Age (In yrs. last birthday) Hours Min 1<del>√</del> M 2 F Yrs 219-44-7929 62 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location 1 ☐ Yes 2 X No MD Balto Essex 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number F. 21221 U SA 2 Sharondale Way 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th grade College (1-4or 5+) Various Jobs Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Luther Martin Nannie Mae Walker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sandra Tapp-Sister 1243 Glenwood Avenue Balto, MD 21239 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt Zion Cemetery 8-09-2010 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lansdown, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F/H East 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Balto, MD 21202 Immediate Cause (Final disease or condition resulting in death) Cancel Lung Due to (of a a consequence of): rneymonia Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 nknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an perform 2 No Yes 25. Was case referred to medical 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only

permit, Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural," or iten any injury or other traumatic event, the Medical Examiner **Physician** /Medical **Examiner** or Attending Physician: The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760, certificate this After within 24 hours after death To the Funeral Director:

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show ns 23a or 28a-f shov must be notified at

items ?

Directo

Funeral

Completed by

Be

2

Examiner

Physician/Medical

Completed by

Medical Certification: To Be

one)

Dr. John

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

funeral

filled in by

the Maryland

altimore, Maryland 21215-0036

laftin, Larr

State

DHMH 17 Rev 1/2001

Registrar

29c. License number

9000 Franklin Square Drive Baltimore MD. 21237

29d. Date signed (Month, Day, Year) #VUV37, 2, 2010

and manner stated.

Hothunti (

1-32. Regist

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kottarathil

State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death A Month Physician/ 150 PM Ρ MORRISON THELMA tuguoi 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimon feel 01 Baltimon N/A If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖵 F Months Hours Min. 0272271923 Country) 214-16-3873 87 POLAND Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director ty Yes 2 No N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 6317 PARK HEIGHTS AVENUE, #618 21215 USA permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give 5-0036 1 ☐ Yes 2X No Specify: WHITE Specify. 3 Widowed 4X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2121 Elementary/Seconday (0-12) College (1-4 or 5+) BOOKKEEPER LEVINDALE HEBREW HOME Be land 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ MORRIS PEREMEL BERTHA BERMARK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA RISBY/DAUGHTER 1818 EAST DEEP RUN ROAD, MANCHESTER, MD Baltimore, 20a. Method of Disposition 20b. Pier & Wispostion New Seach ARI 1 X Burial 2 Cremation 3 Removal from State (NER TAMID) CEMETERY : 08/10/2010 BALTIMORE, MD 4 Donation 5 Other (Specify) 21. Signati 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 910K †Hysician disease or condition resulting in death) Medical Due to a r as a consequence of Examine ymon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? certificate l Yes 2 No 1 Yes 2 No director, Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 2 **X**No ပ 1 Tyes 1 Npatient 2 ER/Outpatient 3 E DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this completed filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1. Natural injury 5 Pending Accident Suicide Investigation after death 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours Medical 1- Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number atel August 9, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOSPITAL OF BALTIMORE, MARYLAND MD. SINA PATEL 31. Date filed (Month, Day, Year) State AUG 1 1 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #11 Per FH G906 8/11/2010JH State of Maryland / Department of Health and Mental Hygien 2 0 | 0 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 8:55 AM Gerald R. McKenzie 20 August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Joseph Richey Hospice Baltimore 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Director 73 Yrs 1936 Michigan 385-34-6424 Nov 10. Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at Director 1 X Yes 2 🗆 No VA Alexandria 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 22314 300 Wythe Street United States Apt. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: "natural" 3 Widowed 4 Divorced White Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Courthouse Reporter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Russell Harwood McKenzie Laura M. Davis 19a. Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alexander McKenzie /Son MD 21201 Jasper Street Baltimore, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or Aug 10 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory 2010 Sign ture of Funeral Service Licenses 22. Name and Address of Facility MOIYY3 Cremation and Funeral Alternatives 8717 Creen Pastures Drive Towson land 21286 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANCER Physician 9 E disease or condition MONTH Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Durinto (unas a cur sequence of) cause. Enter Underlying Cause (Disease or iinjury that initiated events ig physician and as the burial-tran Due to (or as a consequence of): resulting in death) Last the attending physician hed for use as the burial Physician/Medical or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year detached 9 Unknown sate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed within 24 hours after death.

To the Funeral Director, After this certificate 1 Tes Yes 2 🗷 filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Steper (Specify) 2 🗷 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accident 5 Pending work? 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifi-29c. License number 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Ite/h 23a) (Type, Print) N. EUZAW (7#70) BACTIMONE MOZA State Registrar

12/2

Box 68760. P.O. Division of Vital Records.

Baltimore, Maryland 21215-0036

Hospital or Attending To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A

State

Medical

29a. Certifier (Check only one)

29h Signature and title of certifier

RES-000 AUGUST 5 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 JOUTH HANDVER STREET BALTIMORE, MD MATTHEW FANELL 32. Registrar's S

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) ate of Death 3. Time of Death Physician/ Medical give street and number) City, Town, or Location of Death **Examiner** 4c. County of Death Kandallstou 105 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗸 F Months (Month) Country) Director Henal Res ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 3 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married ò Yes 2 No Baltimore, Maryland 21215-0036 If Yes Give 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) stan Be 17. Father's Name (First, Middle, Last) Middle, Maiden Surname, 2 19a. Informant's Name/Relationship (Type, Print) Mother 20a. Method of Disposition 20c. Location - City 20b. Place of Disposition (Name of gemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Dicenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-transi Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy perform 2 🗌 No 1 Yes completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: Certificate: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 28d. Describe how injury occurred Natural injury 5 Pending 2 🗌 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of 29c. License numbe

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day,

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and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 251 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Narany Physician/ Augusi 2010 4 OOPM esus Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death **Examiner** Road OWART LIMPIA evens forest 5 8. Date of Birth (Month Day Year) Sex, 1 X M 2 □ F If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 686 Months Days Hours ork **Director** Usual Residence of Decedent show 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland aţ 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified TOWAR LUMDIO 1 Yes 2 No 0 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral evens - OTEST -5 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian Armed Forces# 1 ☐ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married þ 1 X Yes 2 No Specify: Panana Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Completed 3 Divorced 4 Divorced permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 6 puleSMAN INCT Be Father's Name (First, Middle, Last) -Mother's Name (First Middle, Maiden Surname) ည Naranjo 2015 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 048 Naran 0 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State -14-201C Т fan over TEMATORY Arden 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licenses owel 027 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease disease or condition resulting in death) titeriuscleratio neart Veall Medical Due to (or as a consequence of) Examiner ertension ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury ear cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Dighete Mellitus ear s Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1  $\square$  Yes 3 ☐ Probably 4 ☐ Unknown within 24 hours after death.

To the Funeral Director, After this certificate has been 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 10 VOSCULAR acci autopsy 1 Yes 2 No Yes 2 N 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: 1 🗌 Yes 2 📉 No 4 
Nursing Home Certificate: To 1 Inpatient 2 I ER/Outpatient 3 I DOA 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred iniury Natural 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 
Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Marin 0002626 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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Stevens

COLUMBIA

Md 21046

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AUGUST 08 Day 2010 6:40 A M SHIRLEY NEULANDER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death GILCHRIST HOSPICE CARE TOWSON BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 08/18/1924 Director 85 085-12-6587 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any njury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No N/A BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6300 RED CEDAR PLACE, APT. 21209 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 XNo If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates Specify. 3X Widowed 4 □ Divorced Completed WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) TEACHER EDUCATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 ELLIS LEWIS IDA RUDEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAVID B. SHAPIRO/ATTORNEY 1101 ST. PAUL STREET, SUITE 405, BALTIMORE, MD 21202 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW CEM 08/10/2010 REISTERSTOWN, MD Signature of 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE. 21208 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau cations that caused the decause on each line. Do not enter the mode of dying Approximate Interval Between n et and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live Birth 2 ☐ 1 Gtd. ☐ 4 ☐ Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 roonths? Month Day Year signed by the a 9 Unknown Part II. <mark>Other significant conditions</mark> contributi<u>ng</u> to death but not resulting in the underlyin**g** cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy perform certificate 2  $\square$  No 1 Yes 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 1 🗌 Yes 20 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director. After this completed filled in by the funeral di Manner of Death

Natural

Accident 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending work 1 Yes 2 No Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 1 🔾 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature a d title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

AUG 1 1 2010

nd address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar			tificate of L				Reg. No.	2010	23114
Physicia Medical Exami		Decedent's Name (First, Middle,L.     Nadia	ast) I.		Nawaz			2. Date of De Month August 7		Year	3. Time of Death 0855 hrs
,		4a. Facility Name (if not institution, g				City, Town,	or Location of De			County of Death	
		S/B Old Georgetown Ro	ad @ Rt. 495			Bethesda			M	ontgomery	
Funeral Director		233-39-7685		9 (In yrs. 12 7	ast birthday) Yrs.	If Under 1 You Months Da		lin. Apr. 8		9. Birti Foreigi 3 Phee	
any		Usual Residence of Decedent  10a. State  10b. County		10c. City,	Town or Location						10d. Inside City Limits
≥ 1	'n	Maryland Montgom	ery	Pot	omac						1 Yes 2 No
Maryla	Director	10e, Street and Number			1	Of. Zip Code				en of What Coun	itry?
th the 23a or notifie	Ö	18 Pebble Ridge				20854				.S.A.	
eath wi	Funeral	11. Marital Status  1 Never Married 2 X Marrie	12. Was Decedent Armed Forces?				Hispanic Origin? ( an, Mexican, Pue		0-   1	<ol> <li>Race - Americ</li> <li>White, etc.</li> </ol>	can Indian, Black,
ifter de		3 Widowed 4 Divorce	1 Yes 2	X No	1 Y	es 2X N	lo specify:		s	Specify: Whit	:e
hours a	ed by	15. Decedent's Education (Specify			16a. Decedent's during most		ation (Give kind of fe. DO NOT use r		16b. Ki	nd of Business/Ir	ndustry
36 in 72 l	Completed	Elementary/Secondary (0-12)	College (1-4 or 5	′	Environm	_			F1	nancial	
d with	E	17. Father's Name (First, Middle, Las	• •	ļ	ZIIV ZI OIII	Circux		ne (First, Middle,			
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Mohammad Nawaz					Duree	Shawar			
→ 등 절 : □ : □ : □ : □ : □ : □ : □ : □ : □ :	٩	19a. Informant's Name/Relationship					eet and Number o				Zip Code) LandAL109FD
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Baltir permit. F Departme Importatinijury or	1	Donation 5 Other Specification     Signature of Peneral Service Lice					ss of Facility			ib onare	any virginita
1		MATEL	end mores		1 555	5 Twin	n_KNolls	Rd. Col	umbi	a, Maryl	Land 21045
Physician /Medical	_	23a art I. Enter the disease, or comfailure. List only one cause on	each line.	the death.	Do not enter the r	node of dyin	g, such as cardiad	or respiratory ar	rest, shoc	k, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)	Multiple Injuries  Due to (or as a conse	quence of	):						Death
		ocqueritially hat conditions,	)								
	ji E	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	quence of	):						
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Box 687 e death certific the attending p ed for use as th	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at t	ime of dea	2 Fetal o		Ectopic preg	nancy	V	Month Da	ay Year
BOX death he atter d for u	Physician/	1 Yes 2 No 9 V Unknow		o or doc	5 Other	(Specify)		AAAA AA AA AA AA			
P.O.   ss that the gned by ti	by P	Part II. Other significant conditions	contributing to death	but not re	sulting in the unde	erlying cause	given in Part I.				ne cause of death?
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Cord law rec has bee	Completed							24a. Was autop			opsy findings available ompletion of cause of
Re(	힝	05.11						1 ✓ Yes	2 No	1 Yes	2 No
/ital	o Be	25. Was case referred to medical examiner?  — 1 ✓ Yes — 2 No	Hospital: 1 Inpatier	t 2 1	ER/Outpatient 3		Other Nurs	ing Home 5	Residenc	ce 6 🗸 Other:	Scene
Division of Vital Records, tal or Attending Physician: The law requir rs after death.  al Director: After this certificate has been seled in by the funeral director, page 2 should led in by the funeral director, page 2 should led in by the funeral director, page 2 should led in by the funeral director, page 2 should led in by the funeral director, page 2 should led in by the funeral director, page 2 should led in by the funeral director, page 2 should led in by the funeral director, page 2 should led in by the funeral director, page 2 should led in by the funeral director, page 2 should led in by the funeral director.	-1	27. Manner of Death	28a. Date of Injur	<del></del>	28b. Time of Injur		ury at Work?	28d. Describe	how injury	y occurred	-
tendi death.	읥	1 Natural 5 Pending 2 Accident Investiga	Aug 7, 2010		0845 hrs	1	Yes 2 🗸 No	Driver auto	auto co	ollision	
Divis al or A safter of in by	Certification:	3 Suicide 6 Could no determine	De		me, farm, street, fa	actory, office	building, etc.	or Town, S	State)		al Route Number, City
Tospitz 4 hours unera		4 Homicide	(Specify) Majorian: To the best of my			at the time	tate and place, an				5, Bethesda, Md.
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the arte completely filled in by the funeral director, page 2 should be detached for use the completely filled in by the funeral director, page 2 should be detached for use the completely filled in by the funeral director, page 2 should be detached for use the completely filled in by the funeral director, page 2 should be detached for use the completely filled in by the funeral director, page 2 should be detached for use the completely filled in by the funeral director, page 2 should be detached for use the completely filled in by the funeral director, page 2 should be detached for use the completely filled in by the funeral director.	Medical		er:On the basis of exam and manner stated.								
F ¥ F S	ž	29b. Signature and title of certifier	/			1	se number	·		ate signed (Mont	h, Day, Year)
		Mayent The y	rell			0.0	.M.E.		Augu	st 8, 2010	
'5v		<ol> <li>Name and address of person who Margarita Korell MD. A</li> </ol>	completed cause of de ssistant Medical E	•	•	Street F	Baltimore, MD	21201			
Sta	te	31. Date filed (Month Aug 21		s Signatur		at 1					
Registr		AIII- 1 1'	700 /km	A Bendar		1.5					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITEM#1perPHYS, G906, 8727/2010, WS

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) Oluwatoyin Omotayo Osinuga 2. Date of Death Dav Month **Physician** Omot Osinuga 7/28/2010 Oluwatoyin 8:05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cheverly
If Under 24 Hrs. Prince Georges

Grithplace (State or Foreign Prince Georges Hospital 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** 1 ☑ M 2 🗆 F Months Days Hours 37 Director none 2/1/1973 Nigeria Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medicin Evolution is a marked by 1 ☐ Yes 2X No Director Md. Prince Georges Forestville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7115 Donnell Place #A2 20747 Nigeria death v Funeral permit. Pages 1 and 2 should be filed within 72 hours after dear Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural". or itemary injury or other traumatic events. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ∐Yes 2 No If Yes, Give Year or Dates: black 1 ☐Yes 2 No Specify 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineer Computer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kolawole Mojeed Osinuga 2 Stella Remilekun Balogun 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ganiyat Lateef- Wife 7115 Donnell Pl.#A2 Forestville,Md. 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland National 7/31/2010 Laurel, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Universal Mortuary asly Nar 411 Kennedy St NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each in section of the complex of the com Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Luciosas /Medical Due to (or as a cossequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner equence of) The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year Pregnant at time of death 5 ☐ Other (specify) P.O. After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☐No 1 ☐ Yes 2 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only o e) æ Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending 1 □Yes 2 □No death. investigation To the Funeral Director: completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide after t 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated To the I within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address Demetrios James Catevenis MD301 Hospital Dr. Cheverly Md State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of State of Registrar	Maryland / D		ment of Healicate of De			giene Reg. No.	010	25116
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	Medic Examin		4a. Facility Name (if not institution, give street and numb	er)		b. City, Town, or Lo	cation of Death	11ugube	4c. Co	ounty of Death	0.27 11
-1	Euporol		8070 Keeton Road  5. Social Security Number 6. Sex 7	. Age (In yrs. last birtho		Elkridge	Under 24 Hrs.	8. Date of Birt		vard	olace (State or Foreign
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	and show 1 at	'n	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town of	or Locati	on					10d. Inside City Limits
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936	s after al", or Examir	d by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 If Yes, Give Year or Date	XX <sup>No</sup>		V	Specify:	, noun, etc.,	Spi	Black, White, ecify: Whi	
2-0	2 hours "natur edical	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. D	Decedent Give kind	's Usual Occupation of work done during	in na most of work	ina I	16b. Kind	of Business In	dustry
7121	vithin 7 jiene. <b>er than</b> <b>the Me</b>		Elementary/Seconday (0-12) College (1-4	The state of the s	fe. DO N	oruse retired) nemaker			C	wn Hom	e
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aryla	ould be nd Men marke		Levi Graham  19a. Informant's Name/Relationship (Type, Print)	195.1	Mailing A	ddress (Street and		Adkins		un Stata 7in l	Code)
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nore	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1 🗓 Burial 2 🗆 Cremation 3 🗀 Removal from S	tate	cremato	ory or other place)	İ	Date / OO 1 O		tion - City or To	
Baltimore, Maryland 21215-0036	rmit. Papartme pontan y injun		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	Meadow	22. N	e Memoria		/2010   y, LKa	Elkri ufman	dge,Ma: Funera	ryland 1 Home_@ ,
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<u>≥</u>	ital or us afte ral Dire		building	, etc. (Specify)				City or Town	n, State)		
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2 sompleted filled in by the funeral director, page 2 sompleted filled in by the funeral director.	Medical	29a. Certifier (Check (Check only one) 3 Certifying Physician: To the besis only one) 3 Certifying Nurse Practioner: To	of examination and/or ir	nvestigat	ion, in my opinion, d	leath occurred at	the time, date ar	nd place, an	d due to the ca	use(s) and manner stated.
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	3					Vorth D	2. Sue	te 260	. Col	unbio	MD 21045
	Stat Registra		31. Date filed (Month, Day, Year) 32. Rec	istrar's Signature	A						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Parlaman Month Richard 17:17 2010 August Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical Baltimore N/A (enter If Under 1 Year | If Under 24 Hrs. | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 ₺ M 2 🗆 F 220-72-2350 July 01 Year 1957 Country) Director Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Pasadena 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 112 Maryland Avenue 21122 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14, Race - American Indian. Armed Forces' Black, White, etc. 1 Never Married 2 Married \$ ☐ Yes 2 × No 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates. Specify. White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 Warehouse Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Richard G. Parlaman Cottrell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise L. Paralman (spouse) 112 Maryland Avenue, Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Metro Crematory Inc. 1 Burial 2 Cremation 3 Removal from State Aug Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Sicense 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain road, Pasadena, MD 21122 Part 1. Enter the hillease, or complections that or used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on chuse of sech line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ fibrillahor disease or condition resulting in death) Ventricular Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of, attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year signed by the a d be detached f 1 ☐ res ∠ ∟ 9 ☐ Unknown q 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by mitral valve regurgitation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 \(\sum \) No 1 🗌 Yes 2 🔀 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes Other: 2 X No ၉ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 1003135435 August, 6, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Greene Street, Baltimore, Maryland, 21201 22 Canzoniero,

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

AUG 1 1 2011

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

Division of Vital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) Date of Deat Physician/ Month SPM James Michael Poole 2390 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City Town, or Location of Death town ONS 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 8. Date of Birth (Month, Day, Year) 07/09/1923 1 XM 2 ☐ F Months Days Min. 046-18-3736 87 Yrs. Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Catonsville 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 719 Maiden Choice Lane BR217 21228 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 XYes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 X Married Specify: White 1 ☐ Yes 2 X No Specify Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Salesman Chemical Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ James Poole Florence Marie Berger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer Poole (Daughter) 7279 Steamerbell Row, Columbia, MD 21045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Bayview Crematory 08/10/2010 | Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on wach line Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician; The law requires that the death certificate be executed 24 hours after death. ed by the attending physician and detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months? Day Pregnant at time of death Month Year 2 No Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by completed filled in by the funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a Was an Director: After this certificate has autopsy performe 2 🗌 No Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 100 Other: 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred work? Natural 5 Pending injury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number

DHMH 17 Rev 7/2009

State Registrar 30. Name and addres

onth, Day, Year,

of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Richardson 06:00 PM August 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Glen Burnie Health & Rehab Glen Burnie Anne Arundel Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😾 F Months Hours Janth, Pers Year 936 213-32-6751 74 **Director** Usual Residence of Decedent items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 37 Milburn Circle 21122 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 x Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Operator Telephone Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Masilek Francis Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vernon L. Richardson (spouse) 37 Milburn Circle, Pasadena, MD 21122 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Aug. Maryland Veterans Cem Crownsville, Maryland 4 Donation 5 Other (Specify) 2010 21. Signature of Funeral Service Lie 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or com shock, or heart failure. List only ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Vauan disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): physician and s the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Dav Year signed by the a 9 Unknow Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 2 🗆 No ∐Yes 2 🗶 No 1 Yes Be Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: ျ 1 ☐ Yes 2 💢 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🔼 Natural injury work?
1 Yes 2 No 5 Pending after death. 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Datg signed (Month, Day, Year) D26307 Karpmen Kam S.

State Registrar

DHMH 17 Rev 7/2009

202 W. MAPLERD, LINTHICUM, MD 21090

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KANI S. KAK) 31. Date filed (Month, Day, Year)

AUG

H.D

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 25120 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ August 2010 Jane Eleanor Rymshaw 8:55 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 1213 Seven Oaks Road Arbutus Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛚 F Months Days Hours Director 230-05-6036 88 Virginia Usual Residence of Decedent show 10a, State 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10d. Inside City Limits Director Baltimore MD Arbutus 1 ☐ Yes 2 😾 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral Page 1 and 2 should be filed within 72 hours after death with 1213 Seven Oaks Road 21227 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 O Bank Teller/ Asst. Man. Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental H ပ Milton Lambert Grace Cunningham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philip R. Rymshaw / Husband 1213 Seven Oaks Road, Arbutus, Maryland 21227 other 1 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or otl Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bayview Crematory 8/9/2010 Baltimore, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 WIlkens Avenue, Baltimore, Maryland 21229 2 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Exami nding physician and use as the burial-transit Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 Yes 2 No 1 🗆 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 2 W No 2 1 Inpatient 2 ER/Outpatient 3 IDOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

iden Choice

erson who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10: 30A M June E. Spannow August 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** n/a Union Memorial Hospital Baltimore 8. Date of Birth (Month, Pay Y 6–13–1926 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕅 F Hours 217-20-6599 Director MD Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director MD Baltimore Owings Mills 1 ☐ Yes 2 ☐xNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21117 9773 Groffs Mills Drive USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: African-American If Yes, Give Year or Dates 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) The Nurse Bank Private Duty Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Raymond High Sarah Ourtis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda Denise Booth/ Daughter <u> 100 Sumar Ct., Apt. 3B. Balto. MD 21207</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Garrison Forest Veterans 8-16-2010 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signal re of Funeral Service Licensee Wylie Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Disease (3 vessel Coronary disease or condition resulting in death) GOAY Medical Due to (or as a consequence of) Examiner Aartic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the bunal-transit Due to (or as a consequent of) resulting in death) Last (Stage hronic Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Month Pregnant at time of death g to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

by Physician/Medical Completed Be ဂ္ Certificate:

1 Yes 2 No	4
Part II. Other significant conditio	ns contributing


Hospital:

1 🗌 Yes	2 💢 No	3 Probably	4 Unknown
4a. Was an autopsy performed?	.   .	Were autopsy fi prior to complet death?	

2

University

25. Was case referred to medical
examiner?
1 ☐ Yes 2 X No
27. Manner of Death
. 1501

1 LX Inpatient 2
28a. Date of injury (Month, Day, Year

	ER/Outpatient	3 🗌 1	DOA	Other:	□ Nursing
)	28b. Time of injury		28c.	Injury at work?	
	_	М		1 🗆 Yes	2 🗌 No

26. Place of Death (Check only one)

	1 Yes 2	No 1 ☐ Yes	2 🗆 No
of Death (Check on	ly one)		
4 Nursing Home	5 Residence	6 Other (Specific	y)

Baltimore MD 21218

i pessinaturai	3 La Feriumy
2 Accident	Investigation
3 🗌 Suicide	6 Could not be
4 Homicide	determined

28a. Date of injury (Month, Day, Year)	28b. Time of injury
28e. Place of Injury - At ho	me, farm, street.

building, etc. (Specify)

М	28c. Injury at work? 1 ☐ Yes	2 🗆 No
facto	n, office	

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Contifying Nurse Practioner. To the best of my knowledge, Seath occurred at the time, date and plane, and due to the cause(s) and manner as state

28f. Location (Street and City or Town, State)	Number or	Rural Rout	e Number,

28d. Describe how injury occurred

29a.	Certifier
	(Check
	unity one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. l	icense number	
AT	1438946	

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed	(Month,	Day, Ye	ar)
August	7,	20	10

Parkway

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State Registrar

Medical

Hanna

Memorial istrar's Signature

Hospital, 201 East

DHMH 17 Rev 7/2009

within 24 hours a

To the Funeral D

completed filled in

State of Maryland / Department of Health and Mental Hygien 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav Word onina 640 A M August Medical 2010 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospital Baltimore Sina 0 Coty Baltimore Social Security Number Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Hours 1 M 2 W 584-58-8963 **Director** 28a-f shov 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2120 within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married è Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Black 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Shire lang, Wongshing permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other any injury or other traumatic event, the once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ brothe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Termation 3 Removal from State Cremator 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee ud MD 21281 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between ર Immediate Cause (Final disease or condition Onset and Death Physician/ A cutte Myocandial Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) the attending physician Physician/Medical 8 as the l IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No ŏ Month Day Year Pregnant at time of death 9 Unknown P.O. signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s After this certificate has autopsy performed the Hospital or Attending Physician; The 1 Yes 2 No 25. Was case referred to medical **Division of Vital** funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending death. 1 🗌 Yes 2 🗆 No 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death

To the Funeral Director,
completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) it Kabasa.. MBBS RES-000 August 6 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MBBS Hospital 3. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 1 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Phown

10-05972 William Scott Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Iliam Scott		artment of Health and Mental H	ygiene 2010 2512:
	1- For State Cel	rtificate of Death	Reg. No.
Physician/ edical Examine			2. Date of Death Month Day Year AUgust 8, 2010  3. Time of Death 2135 hrs
	Facility Name (if not institution, give street and number)     S200 Bowleys Lane Apt 109	4b. City, Town, or Location of Death Baltimore	4c. County of Death
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. la		- I
Director	217-38-2177 12m 20F	70 Yrs. Months Days Hours Min	Jan 19, 1940 Foreign Country) MD
á	Usual Residence of Decedent  10a. State 10b. County 10c. City.	Town or Location	10d. Inside City Limits
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	mp N/A	Sattimore	1 Yes 2 No
r death with the Maryland or items 23a or 28a-f sh must be notified at onco Funeral Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
th the 23% or notific	5200 Bowleys Ln Apt	109 21206	<u>usa</u>
items ust be undergo	11. Marital Status 1 Never Married 2 Married Armed Forces?	S. 13. Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puerto	
rs after de ural", or miner mi	3 Widowed 4 Divorced or Dates:	1 Yes 2 No specify:	specify: Black
hours Frami	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use reti	
5-0036 led within 72 hour tygiene. other than "natu the Medical Exan Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Truck Driver	Transportation
5-00 led wit Hygien other the Mc	17. Father's Name (First, Middle, Last)	18.Mother's Name	(First, Middle, Maiden Surname)
21215-0036 uld be filed within 7 Mental Hygiene, marked other than c event, the Medica	William M. Scott	Edna	Christian
MD 2 nd 2 shoul alth and N m 27 is m To	19a. Informant's Name/Relationship (Type, Print) Tammy Tolley - daughtou	193 Magnotia Dr	Rural Route Number, City or Town, State, Zip Code)
Te, N 1 and 1 and Thealth fitem	20a. Method of Disposition 20b. F	Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State
Baltimore, permit. Pages l ar Department of Hee Important: If ite	4 Donation 5 Other Specify:	godlawn Cemetary 8	113/2010 Baltimore, MD
Balt Departs Import Injury	21. Signature of Funeral Syrva Librarsed	22. Name and Address of Facility	owell Funeral Home
Physician	23a. Part I. Enter the disease, or complications that caused the death.	Do not enter the mode of dying, such as cardiac of	
/Medical Examiner	failure. List only one cause on each line.  Immediate Cause (Final disease a Hypertensive Atheroscle	erotic Cardiovascular Disease	Between Onset and Death
LXaIIIIICI	or condition resulting in death)  Due to (or as a consequence of		
Ter .	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of	f):	
ted Insit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of	r):	
50, te be executed tysician and burial - transit	d		
e be execut ysician and burial - tra	UNPENDED AMENDED		
Sox 6876/death certificate e attending phy for use as the tysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregration 1  Live birth	nancy  Petal death 3 Ectopic pregna	23d. Date of delivery incy Month Day Year
Box 6876 e death certificate the attending phy ed for use as the hysician/M	4 Pregnant at time of deal	ath 5 Other (Specify)	
O. Bo at the des by the a ached fo		esulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
Records, P.O. The law requires that it ficate has been signed by page 2 should be detac. Completed by F.	Diabetes Mellitus		1 Yes 2 No 3 Probably 4 V Unknown
Records, The law require ficate has been si , page 2 should b			24a. Was an 24b. Were autopsy findings available prior to completion of cause of
ital Recorician: The law is certificate has be rector, page 2 sh			performed?   death?   1  Yes 2 No 1 Yes 2 No
Vital Recysician: The I	25. Was case referred to medical examiner?  Hospital:   Inpatient 2	26 Place of Death (Check of ER/Outpatient 3 DOA Other Nursin	only one) g Home 5 Residence 6 ✔ Other Scene
Ing Phys After thi funeral di	1 ✓ Yes 2 No 1 Inpatient 2  27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred
Ision of Attending a death.  rector: A by the fur	1 V Natural 5 Pending 2 Accident Investigation (Month, Day, Year)	1 Yes 2 No	
:> 호흡급트 📜	3 Suicide 6 Could not be 28e. Place of Injury - At ho	me, farm, street, factory, office building, etc.	<ol> <li>Location (Street and Number or Rural Route Number, City or Town, State)</li> </ol>
lospita t hours uneral	29a Certifier	ne death occurred at the time, date and place, and	due to the cause(s) and manner as stated
To the Hospital within 24 hours To the Funeral completely filled	(Check only one) 2 Medical Examiner; On the bast of my knowledge one) 2 Medical Examiner; On the basts of examination are and manner stated.		
Re see a	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	- Totalle Tollen	O.C.M.E.	August 9, 2010
4v	Name and address of person who completed cause of death (Item:     Patricia Aronica-Pollak MD.		e, MD 21201
State	31. Date filed (Month, Day, Year) 32. Registrar's Signatur		
Registrar	NOU E Z ZUIU / U. STONE AND	1620 000	

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 8 STANTON CATHERINE 0930 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5 ST. MARY'S NURSING CENTER MARY EONARD TOWN, MD ST. If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 7. Age (In yrs. last birthday) g. Birthplace (State or Foreign **Funeral** Days Months Hours Min. NoWonth 3 Pay, Year 15 Virginia 94 Director 578-12-8429 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Saint Marys Ridge 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? ıral", or items 23a o Examiner must be Funeral USA 20680 50010 Fresh Pond Neck Road within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. δ 1 Never Married 2 Married ☐ Yes 2 🔀 No Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", 3 X Widowed 4 Divorced Completed h and Mental Hygiene.

I is marked other than "natural".

The Medical E. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 self employed restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be:
Department of Health and Menta
Important: If item 27 is marked
any injury or other traumatic ew ည William Wolfe Estella Wolfe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Doreen Bickel - granddaughter 500100 Fresh Pond Neck Road; Ridge, MD 20680 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 

Burial 2 

Cremation 3 

Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board atur Tuneral Service Liver 655 W. Baltimore Street; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the moon of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each time. Approximate Interval Between Onset and Death Immediate dause (Final Physician/ disease or condition resulting in death) mo Medical We to (or as a consequence of) **Examiner** Sequentially list conditions, if any cooling to inscitate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death 1 Yes 2 V cate has been signed by the page 2 should be detached 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate l 1 Yes 2 No 2 No Yes ieral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? M Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) within 24 hours a

To the Funeral D

completed filled i Medical 29a. Certifier 1 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who pleted cause of death (Item 23a) (Type, NURSING CEN 10 St. 21585

Registrar DHMH 17 Rev 7/2009 ARDTOWN, MO

20650

JARBOK

Year)

MD

32. Registrar's Signature

J. PATRICK

31. Date filed (Month, Day,

AUG 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #20a-c Per FH G906 8/11/2010 JH
State of Maryland / Department of Health and Mental Hygiene
amend item 20b per fh g906 8-27-10 vt 20c
Certificate of Death

Reg. No. For State Registrar 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010° 743 John Martin Strapac August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. g. Birthplace (State or Foreign Country) Pennsylvania Social Security Number 8. Date of Birth (Month, Day, Year) **May** 31, 1916 7. Age (In yrs, last birthday) Funeral Months 1 X M 2 D F 94 Director 209-03-4418 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 XNo Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21046 7518 Water Lilly Way U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. A Black, White, etc. 1 Never Married 2 Married ğ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3XXWidowed 4 □ Divorced Completed Army 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 10 Steel Mill Foreman Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any hjury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Adam Strapac Mary Pavelak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7518 Water Lilly Way Columbia, Maryland 21046 Christine Thomas (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of Community C Date UNK 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Gilpin Township Donation 5 Other (Specify) Catherine Cemetery 8-12-10 Leechburg, PA 21. Signature of Funeral Service Licensee Witzke Funeral Hones, Inc. 5555 Twin Knolls Road Columbia, Maryland 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Drady Cardie disease or condition resulting in death) Medical Due to (or as a onsequence of): Examiner COROMOLO Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exami and -transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Dav Year 1 Yes 2 No ate has been signed by the page 2 should be detached g 🗌 Unknown Part L Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Periphoul only disease Hospital or Attending Physician: The law requires 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed diabetes me llitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ryper apidencia performed' 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No ျ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) SUITE SZO ANNAROLIS MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PARICWA 1CA7 State Registrar

DHMH 17 Rev 7/2000

Box 68760

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ (2:18 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day Birthplace (State or Foreign Country) Funeral 7. Age (In vrs. last birthday) 1 X M 2 🗆 F Days 50194 Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 No more 10e, Street and Number 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 X Married Completed by 1 ☐ Yes 1 ☐ Yes 2 X No Specify: 3 🗆 Widowed 4 🗀 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type, Print) laylor lannie 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice Baltmore 23a. Part 1. Enter tris disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ ardiogenic disease or condition Medical resulting in death) Examiner monary Sequentially list conditions, if any sound to have classes. Enter Underlying Cause (Disease or linjury that initiated events Examine One to (or as a nonsequence of): Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 🗌 No 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital Other: ျှ 1 🗌 Yes 1X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes of injury 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending Accident 2 🗌 No Investigation the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier DOOL 7708 30. Name and address of person whb completed cause of death (Item 23a) (Type, Print) 410-332 87. loma. 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#16a,b, 20a-c, 22perFH, 6906, 8/17/2010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Day 05:20 AM Thomas 2010 Anna August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SINAL HOSPITAL OF BALTIMORE CITY BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🛛 F Months Days Hours Min. Oct 24, Year 981 Maryrand 28 218-98-2629 **Director** Usual Residence of Decedent or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director MD Baltimore 1 🔀 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21217 USA 2613 Reisterstown Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: black Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry unk (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Laborer Baltimore City Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bobby Thomas Mildred Carey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rhonda McCain - sister 2120 E. Hoffman Street; Baltimore, MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 ☐ Burial 2 🗶 Cremation 3 ☐ Removal from Stat 4 ☐ Donation → Other (Specify) 8/13/2010 Baltimore, MD On-Site 22. Name and Address of Facility March LVH, West of Funeral Service Licensee Wäbash Baltimore. Ave. 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ Secsis days disease or condition resulting in death) Medical Due to or as a consequence of): Examiner Cryptococcal Meningihis Secure finity list ou with us Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) attending physician and for use as the burial-transit /AIDS Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? Yes 2 No 2 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 ☐ Yes 2 ☑ No Other: 1 ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 24 hours after death. Funeral Director: After work? injury 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number August 01 2010 Kina Kaspharunesu RES-000

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Registrar

DHMH 17 Rev 7/2009

State

SINAI HOSPITAL

BALTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROOPNARINESINGH, MBBS

32. Registrar's Signature

31. Date filed (Month, Day, Year)

AUG 1 1 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 16a, b per fh g906 8-11-10 yt. State of Maryland Department of Health and Mental Hygiene Certificate of Death 25128 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2010 Month Auswit **Physician** Roy 1140 MM Thomas /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner endellsto Seltimore R HOLD: If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 11-30-1939 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sey 7. Age (In yrs. last birthday) **Funeral** 1 M 2 ☐ F 70 Yrs. 242-58-3192 N.C. Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other then "naturel", or Items 23s or 28s-f show other traumatic event, the Madical Examinar must be notified at Yes 2 No MD Director na Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 123 W. 29th Street 21218 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status filed within 72 hours after Hygiene. 1 Never Married 2 ☐ Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Heelth and Mental Hygiene. int: if Item 27 is marked other then ' Elementary/Secondary (0-12) College (1-4or 5+) 10th grade Disabled Disabled 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) unk Be 2 Mable Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward K. Tyler-Cousin P.O. Box 1074 Osford, N.C. 27556 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If It any injury or o 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) King Memorial Pk 8-13-2010 Randallstown, MD 21. Signature of Funeral Service License 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202 Malle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SYSTEM DICAH **Physician** /Medical Due to (or as a consequence of): Examiner ta: lure RehaL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine inding physicien and use as the burial-transit betes To the Hospital or Attending Physician: The law requires that the death certificate be executed Ch Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical ettending | 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? nas been signe e 2 should be by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an has page certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: ဥ 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 29a. Certifier (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 053850 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Northwest ELEL

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

**ORIGINAL** 

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Hospital

State Registrar

Medical

29a. Certifier (Check only one)

29b. Signature and title of certifier

DHMH 17 Rev 1/2001

within 2

and manner stated.

32. Registrar's

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2 Medical Exeminer: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

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29d. Date signed (Month, Day, Year)

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3	and	snow I at	.or	Usual Residence of Decedent  10a. State 10b. County			Town or Loc			-			1	0d. Inside City Limits
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10	death	ner mu	Funeral	11. Marital Status	12. Was Decedent	?	13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin an, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	- 1	4. Race	- America	an Indian,
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9	be filed ental Hy	ic event	To Be	17. Father's Name (First, Middle, L Seymour Rur	•	-			18. Mother's Mazie	Name (First, Middle Barnes	, Maiden S	urname)		
	Baltimore, Maryland 21215-0036  permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	er traumat		19a. Informant's Name/Relationsh Tina Guevara		· I				r Rural Route Numb berdeen	er, City or T , Mary	own, Sta 7 Lan	te Zip 2	ମିଂପ 01
DoD	Baltimore, permit. Page 1 and Department of Hea	ant. Il iteli		20a. Method of Disposition  1  Burial 2  Cremation 4  Donation 5  Other (S	3 ☐ Removal from Stat	20b. Pla St cell of (	ce of Dispos Tames Grave	sition (Name of natoAx or Mher Day 1 Hill	hurch	614/10	20c. Loc Harv	ation - C	e G	wn, State race, MD
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Va	Division of Vital Records, P.O. Box 68766 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  Within 24 hours after death.	ned for use	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1  Live Birth 4  Pregnant 9  Unknown	at time of deal	death 3	Ectopic pregnand Other (specify)	су		2	3d. Date Mont		ery Day Year
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027				30. Name and address of person v	who completed cause of		(3a) (Type, P	rint)	12598	ر	170	ig ¿	STH	,2010 e 21078
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Martha Genevieve Vanneman 2:08 P.<sup>M</sup> 08 2010 August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Upper Chesapeake Medical Center Harford County Bel Air 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign
Country) **Funeral** Months Days Hours Min. Director 143-16-3791 89 July 01,1921 Rising Sun, MD. Usual Residence of Decedent tat 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f Maryland 1 Yes 2 No Harford County Bel Air 10e Street and Number 10f. Zip Code ö 10g. Citizen of What Country? "natural", or items 23a or dical Examiner must be Funeral 1001 Southern Drive 21014 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ 21215-0036 within 72 hours after 1 ☐ Yes 2 🛂 No Specify: If Yes, Give Year or Dates Specify: White 3 Nidowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Office Manager Insurance of Health and Mental Hygie item 27 is marked other other traumatic event, ti Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Lawrence Gibson Olive Russell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Mrs. Lynn Van Natta (Daughter) 924 Coteswood Circle Cockeysville, MD. 21030 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛎 Burial 2 🗆 Cremation 3 🗆 Removal from State Parkwood Cemetery Aug. 13, 2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Jeffrey L. Gair, Sr. Peaceful Alternatives Funeral & Chemetion Center, P.A. Lic.#M00677 2325 York Road Timonium, Maryland 23a Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Completed by Physician/Medical Physician; The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) fo in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 = 9 Unknown page 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 🗌 No 1 Yes Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA Division of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: Hospital or Attending Natural 5 Pending 1 Yes 2 No Accident Investigation Director: Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. . Certifying Nurse Practionar: To the best of my knowledge, death uncomed at the time, date and place, and due to the naise(s) and many or as state.

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2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 Apuna 31. Date filed /M 32. Registrar S gnature State Registra DHMH 17 Rev 7/2009 **ORIGINAL** 

10-05984 Jaqueline Wesley

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ate of Maryland / Department of Health and Mental Hygiene	21		U	25	,	J

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	1	4a. Facility Name (if not institution 633 Aisquith Street A			er)			City, Town, Baltimore	or Location	of Death		40	c. County o		
5	Ļ	5. Social Security Number	6. Sex		Age (In yrs. Ia	ast birth		If Under 1 Y	ear If Und	der 24Hrs.	8. Date of Bir	h/MM	N/Z		hplace (State or
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876 tificat ng ph as the		23b. Was decedent pregnant in t past 12 months?	ne	1 Live birth		2	Fetal	death	B Ectop	ic pregnan	су		Month	,	ay Year
Box 68 e death certificate attending ed for use as	SICIAL		known	T     T	at time of dea	ath 5	Othe	r (Specify)				Ť			
BC he dez	≘L	Part II. Other significant condi		9 Unknown		eultina	in the unc	fertying caus	e given in F	Part I	23e Did to	bacco	use contri	bute to t	the cause of death?
Division of Vital Records, P.O. B all or Attending Physician: The law requires that the d attendent.  all Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached	3	Diabetes, Asthma, M		_	atti but not re	33uning	in the dire	icitying caas	c given iii i	GIT I.				1.1	ably 4 Unknown
ords, we requires to been signered should be	najaidillo	Diabotos, 7 totimia, 11		000011							24a. Was	an			topsy findings available
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ing Physi ing Physi After this		1 Yes 2 No 27. Manner of Death	_	28a. Date of I	njury		ime of Inju		njury at Wo		28d. Describe I				
on conding ath.		1 V Natural 5 Pen		(Month, Day	y,Year)			1	Yes 2	No					
IVISIOI or Attendather death Director:	2		stigation Id not b	28e Place of	Injury - At ho	ome, far	m, street,	factory, offic	e building,	etc. 2			and Numbe	r or Ru	ral Route Number, City
Dital o	Cerumcation.		rmined								or Town, S	(ate)			
		(0.1001.01.1)	hysicia	an: To the best of	my knowled	ge, deat	h occurre	d at the time,	date and p	lace, and d	lue to the caus	e(s) a	nd manner	as state	ed.
To the within 2 To the complet	Medical	_		and manner state	xamination ar	na/or in	vestigatio				the time, date				
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		( uclo - V	Al	- 40		00 1			J. 181. be.			, , , ,	545t 0, 2		
		<ol> <li>Name and address of person Victor Weedn MD JD</li> </ol>		completed cause of ssistant Medic			111 Pe	nn Street,	Baltimo	re, MD 2	21201				
Sta	9				trar's Signatu	ıre :		4							
Registra	ar	31. Date filed (Month, Day, Year)	0	6		p. 2 60	a produced	7							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien [ 1- State Registrar Amend Item 2 per dr., g906,08/dr2i/i2910dhbeath Reg. No. 1. Decedent's Name (First, Middle, Last) 2, Date of Death 2010 3. Time of Death **Physician** August John Hubert Wolford 2:26 Рм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 12507 Bowling Street Cumber land Allegany If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Nov 8, 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. West Virginia 1 X M 2 □ F 1932 77 Director 217-30-1426 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f shovevent, the Wedgel Evanding on Director 1 ☐Yes 2 TXNo Cumber land MD Alleganry 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12507 Bowling Street 21502 items 23a USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 文字 2 □ No 1953-13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ⊠Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 'natural', or white 1 ☐ Yes 2 ☑ No ģ Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Unit 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed withir nent of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 factory Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charlotte Mae Emerick Vaughn Allen Wolford ပ 19a. informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 Is
any injury or other trau
once. 12507 Bowling Street; Cumberland, Maryland 21502 Cathy V. Wolford - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signal e o Funeral Sarv 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause IFinal disease or condition resulting in death) Myocardial **Physician** 40W /Medical Due to (fr as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the as attending IF FEMALE: use yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery for 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 12 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 210 1 ☐ Yes 2 No funeral director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 | Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after deat To the Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) non M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Va S histopher non. 32. Registrar's agnatur 31. Date filed (Month, Day, Year) State AUG 1 1 2010 Registra

amend #11, State of Waryan 2200 Sarahere of Flaggand Manda All giene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Williams AO ID AM 10:21 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Johns Hopkins Medicune Bethesola Maryland Montgomery Social Security Numbe 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) UTIK Funeral 1 X M 2 D F Hours Jan 20 1952 261-08-5761 Director 58 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Silver Spring 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20910 USA 2015 East West Highway 12. Was Decedent Ever in U.S. Armed Forces? Unk Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status unk 14. Race - American Indian. Black, White, etc. Completed by Never Married 2 Married Baltimore, Maryland 21215-0036 black 1 ☐ Yes 2 X No Specify. If Yes, Give 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Food unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephanie Terry - friend 6800 Osage ST. Berwyn Heights,MD 20740 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 XX remation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify) Final Journey Crem. 8/17/2010 Woodbine, MD Maryland Cremation Services Signation of Funeral Socice Licensee P.O. BOX 141301 Baltimore MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner odistriam equantially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi that initiated events Due to (or as a onsequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death 2 🗌 No 1 ☐ Yes 2 ☐ Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4-Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has k autopsy 1 ☐ Yes 2 ☐ No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 🗆 Pending work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and till 29d. Date signed (Month, Day, Year) 10 30. Name and accress of person who completed cause of death (Item 23a) (Type, Print) 8000 Old aborge town Rd Bethesda MD abolf
32. Registrar's Signature ionth, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Shirley S. Wood August 08,2010 6:00 A. M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Center Baltimore County Towson 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🔀 Hours 215-32-5911 August 09, 1935 Director York, PA. 74 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic events. 28a-f show 10b. County 10d. Inside City Limits 10c. City, Town or Location Funeral Director Maryland Baltimore County 1 Yes 2 No Phoenix 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3830 Dance Mill Road 21131 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc Be Completed by 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clerk PDP Hunt Valley 12 N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Ralph Singer Rhoda Krout 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Robert Wayne Wood (Son) 3830 Dance Mill Road Phoenix, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State Fairview U.Meth.Ch.Cem. Aug. 11, 2010 4 ☐ Donation 5 ☐ Other (Specify) Jarrettsville, MD. 22. Name and Address of Facility

Peaceful Alternatives Funeral & Cremation Center, P.7

Pimornium, Maryland 21093-2215 Signature of Funeral Service Licenses Jeffrey L. 23a. 1. Inter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or it art failure. List only ne cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death pmc Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any leading to immediate cause. Enter Underlying by Physician/Medical Examiner Due to for ea a considuence of: the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and physician and s the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) Pregnant at time of death Month Year Day 1 Yes 2 D 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Certificate: To 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Natural 28c. Injury at 28d. Describe how injury occurred work? iniury 5 Pending 2 🗆 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License numbe address of person who completed cause of death (Item 23a) (Type, Print) rues 70 (D NOCIO

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year

Bark

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 8,18 per fh 9906 8-16-10 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 6:40 pirt 2010 a Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical Himone Age (In yrs. last birthday) 1 Year Days If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months 1 🕅 M 2 🗆 F Country 091-64-9729 Director 68 Tamacia June 7. Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene.
item 27 is marked other than "natural" actions of the control of the co 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits Director Baltimore MD 1 🔀 Yes 2 □ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21215 U.S.A. 3912 Ridgewood Avenue 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🌠 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black Completed 3 🗌 Widowed 4 😾 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Self-Employed College (1-4 or 5+) Artist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Palmer Easton Watt Violet <del>Unknown</del> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tamara Watt/ Daughter 1434 Taylor Avenue, Bronx, New York 10460 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oak Lawn Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) August 13, Baltimore, Maryland 2010 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services 8800 Harford Road, Parkville, Maryland 21234 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death diate Cause (Final Inmediate Cause (Fi Physician aspiration Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi that initiated events resulting in death) Last signed by the attending physician and detached for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 5 Other (specify) Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate has 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Hospital: Other: ျ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 \( \text{Yes} 2 \( \text{No} \) 28d. Describe how injury occurred 1 Natural iniury 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2010 000 ath (Item 23a) (Type, Print) 30. Name and address of person who 2. Registrar's Sign State Registrar

		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Reg. N2 0 1 0 25 137
Phys		1. Decedent's Name (First, Middle, Last)  Maradel Ward  2. Date of Death Month Day Year August 8, 2010  8:15 A M
/Me-	dical iner	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
Funer	20	Glen Meadows Retirement Community Glen Arm  5. Social Security Number 219-22-4904  6. Sex 1 M 2 X F  82 Yrs.  8. Date of Birth (Month, Day, Year) October 14,1927  1 Age (In yrs. last birthday) North Days Hours Min.  9. Birthplace (State or Foreign (Month, Day, Year)) Country)  1 Larsdown, PA
70		Usual Residence of Decedent  10a. State
Maryla a-f sho	ctor	MD Baltimore Glen Arm 1□Yes 2XNo
th with the 23a or 28	Funeral Director	10e. Street and Number 11630 Glen Arm Road, Apt. L59 10f. Zip Code 21057 10g. Citizen of What Country? U.S.A.
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then Z7 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, 11 Medical Experiment in the protified at	by Funer	11. Marital Status  1
Baltimore, Maryland 21215-0036 sermit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or my Injury or other traumatic event, the Medical Examination of the straumatic event, the strain of the strain	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Homemaker  16b. Kind of Business/Industry At Home
/land /	To Be C	17. Father's Name (First, Middle, Last)  John M. Clayton, Jr.  18. Mother's Name (First, Middle, Maiden Surname)  Olga Jester
Mary d 2 sho lith and t7 is ma		19a. Informant's Name/Relationship (Type. Print) Husband G. Fletcher Ward, Jr.  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  11630 Glen Arm Rd. Apt. L59, Glen Arm, MD 21057
More, Pages 1 an ent of Hea nut: If item 2 ry or other		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State  20c. Location - City or Town, State  20c. Forest Hill, MD
Balti permit. I Departm Importa any Inju	ODCE.	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Evans Funeral Chapel & Cremation Services 3 Newport Drive Forest Hill, Maryland 21050
Physicia	_	23a. Parr 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. The last of the mode of dying, such as cardiac or respiratory arrest, and Death of the mode of dying, such as cardiac or respiratory arrest, and Death of the mode of dying, such as cardiac or respiratory arrest, and Death of the mode of dying, such as cardiac or respiratory arrest, and Death of the mode of dying, such as cardiac or respiratory arrest, and Death of the mode of dying, such as cardiac or respiratory arrest, and Death of the mode of dying, such as cardiac or respiratory arrest, and Death of the mode of dying, such as cardiac or respiratory arrest, and Death of the mode of dying, such as cardiac or respiratory arrest, and Death of the mode of dying, such as cardiac or respiratory arrest, and Death of the mode of dying, such as cardiac or respiratory arrest, and Death of the mode of dying, such as cardiac or respiratory arrest, and Death of the mode of dying, such as cardiac or respiratory arrest, and Death of the mode of dying, such as cardiac or respiratory arrest, and Death of the mode of dying, such as cardiac or respiratory arrest, and Death of the mode of dying, such as cardiac or respiratory arrest, and Death of the mode of dying, such as cardiac or respiratory arrest, and Death of the mode of dying, such as cardiac or respiratory arrest, and Death of the mode of dying, such as cardiac or respiratory arrest, and Death of the mode of dying, such as cardiac or respiratory arrest, and Death of the mode of dying, such as cardiac or respiratory arrest, and Death of the mode of dying, such as cardiac or respiratory arrest, and Death of the mode of dying, such as cardiac or respiratory arrest, and Death of the mode of dying, such as cardiac or respiratory arrest, and Death of the mode of dying, are the mode of dying, and Death of the
be executed : Examine cian and burial-transit	_	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  Let (i) as a consequence of it.  Due to (or as a consequence of it.)  Due to (or as a consequence of it.)
760, e be exe sician a		resulting in death) Last  Due to (or as a consequence of):
Box 68760, eath certificate be exattending physician for use as the burial	Medic	IF FEMALE:
o he d	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1   Yes   2   No   9   Unknown   Unknown   23c. If yes, outcome of pregnancy   23d. Date of delivery   23d. Date of delivery   Month   Day   Year
cords, P. w requires that t s been signed by s should be detac	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
Division of Vital Records, or Attending Physician: The law requires that deer death. Director: After this certificate has been signed in by the funeral director, page 2 should be come.	Completed	## A L 2 H E M B P'S DEMENTA  24a. Was an autopsy findings available prior to completion of cause of death?  1   Yes   2   No
Vital Fician: The certificate rector, pag	a	25. Was case referred to medical examiner?  Hospital: Description of Death (Check only one)  Other: Check only one)
E g g	tion: To	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No  28d. Describe how injury occurred
Division of Vital Re To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification: To	3 Suicide 6 Could not be determined 6 Homicide 7 Homicide 8 Homicide 8 Homicide 8 Homicide 8 Homicide 8 Homicide 9 Homicide 8 Homicide 9 Homici
he Hospit in 24 hours he Funera pletely fille	Medical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
To t with To t	Σ	29b. Signafure and title of certifier  Remana 13 alan MD  29c. License number  29d. Date signed (Month, Day, Year)  5/7/2010
0	State	30. Name and address of person who completed cause of death (Months, Day, Year)  31. Date filed (Months, Day, Year)  32. Registrar's Signature
Regi	strar	AUG 112010 Land 1. 1000000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1-Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 635 AM **Physician** 00 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 X M 2 □ F 6 9 Yrs OREA 480-68-824 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Funeral Director HOWAR LLICOT 10f. Zip-Code 10g. Citizen of What Country 10e. Street and Number ō items 23a 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: ASIAN þ 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) COUTURY 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State Date 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the shoek, or heart failure. List only one cause on each line. Immediate Cause (Final Myocardial **Physician** disease or condition resulting in death) /Medical as a consequence of) **Examiner** Sequentially list conditions, if ny lamin imm to cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of physician and as the burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death
9 Unknown 5 Other (specify) 2 No 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Tyes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 2 Accident (Month, Day Year 1 Yes 2 No

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed eral Director: A filled in by the f within 24 hours a

To the Funeral C completely

State Registrar

Medical

3 Suicide

29a. Certifier

one)

4 Homícide

29b. Signature and title of certifier

Could not be

determined

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) Res-000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

600 North Wolfe St, Baltimore, MD, 21287

30,2010

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #9 Pestanna Ran Cana Abadra Pala Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middln. Last) 2. Date of Death Physician/ Young 082Bh J Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Center medical Baltimore City Mercy Baltimone Birthplace (State or Foreign Country) UNK 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral Days 1 ☑ M 2 □ F Hours Min. 214-84-13 Director Usual Residence of Decedent 28a-f shov 10a State 10c. City. Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at 10d. Inside City Limits Director MD 1 Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 21212 12. Was Decedent Ever in U.Sunk 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status unk 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Specify: black Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation unit 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Coilege (1-4 or 5+) unk unk permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) unk ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unkDenise Whiting - friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ State 22. Name and Address of Facility State Anatomy Board Signature of uneral Service Licensee RONALO 23a. Part | Enter the diser e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease are constituted) 655 W. Baltimore Street; Baltimore, MD 21201 Approximate Interval Between Onset and Death Physician/ Pleural disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner leavs Havanced Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner ed by the attending physician and detached for use as the bunal-trans Due to (or as a consequence of): the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Vear Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 Tyes To the Funeral Director. After this certification and the funeral Director. After this certification and the funeral director, f 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 🖸 No Other: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Mariner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifie

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Si

740508720

6304 Young Buck Circle

10-05914 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 State of Maryland / Department of Health and Mental Hygiene Calvin Chiman Yeung 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Month 2326 hrs August 6, 2010 Medical Examiner Calvin Chi Man Yeung 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Funeral <sup>oreign</sup> HongKong Months Days Hours Director 10-16-1969 1X X M 2 F Yrs 085-76-0760 40 Usual Residence of Deceden 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 X No MD Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
Intit If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Anne Arundel Severn Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7971 Jasons Landing Way 21144 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Forces? 1 Never Married 2 x x Married Yes 3 Widowed Specify: Asian 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: ş Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Lead Computer Engineer Noblis 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Kin Kwan Yeung Kwai Lan Lau 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tiffany Chan - wife Jasons Landing Way, Severn, Maryland 21144 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Baltimo
permit. Pages
Department of
Important: I Meadowridge Mem Park. 08-14-2010 Elkridge, Maryland Donation 5 Other Specify 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signatur of Funeral Inc., 7250 Wash Blvd., Elkridge, MD 21075 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. (Medica) Death a. Gunshot Wounds of Head and Torso Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine dause: Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED attending physician for use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Fetal death 2 past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has brector, page 2 sh performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director. Be Other Nursing Home 5 Residence 6 Other After this 1 Yes 28a. Date of Injury 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject shot Aug 6, 2010 To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Natural 2218 hrs 1 Yes 2 ✔ No Pending Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Sufcide 1170 at 1100, Severn , MD determined (Specify) Major Road / Highway 4 V Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) onature and title of certifie August 7, 2010 O.C.M.E. and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001

Registrar

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31. Date filed (Month, Day, Year)

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e filed (Month, Day, Year)
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Smith ArE Swit 203 BACTO MD 2120

			Tor State of Maryland / Department of Health and Mental Hygiene  1 - State Registrar Certificate of Death Reg. No. 2010 251										11.2	
	Dhysisis	- /	1. Decedent's Name (First, Middle						2. Date of De	2. Date of Death 3. Time of Death				
	Physicia Medic	al	Geneva	Elsi	.e	At	kinson		Month Augus	rust 2, 2010   4:45 A M				
4	Examir	er	4a. Facility Name (if not institution) Devlin Manor	in Manor Health Care Cente				4b. City, Town, or Location of Death  Cumberland			ounty of Deat Alle	<sub>th</sub> egany		
	Funeral Director		5. Social Security Number 214-07-0010	4 1 4 0 57 -	e (In yrs. la 88	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		th y, Year) 1921	g. Bir Co Mar	thplace (State ountry) 'Yland	or Foreign	
	and show at	ō	Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town or Loc	cation		· · · · · · · · · · · · · · · · · · ·			10d. Inside C	ity Limits	
	Maryla 28a-f s otified	irect	MD Al	legany		Cum	berland					1 🗓 Yes	s 2 🗆 No	
	ith with the Maryland ms 23a or 28a-f show must be notified at	<b>Funeral Director</b>	10e. Street and Number 701 E. 4th S	treet, Apt 2	11		10f. Zip Code 2	1502		10g. Citize	on of What Co USA	ountry?		
920	'2 hours after death v "natural", or items edical Examiner mu	ρ	11. Marital Status 1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 Å Divorced	ied 12. Was Decedent E Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates.			Vas Decedent of H Yes, specify Cuba ☐ Yes 2 🟋 No		Specify Yes or No- to Rican, etc.)		. Race - Ame Black, White pecify:			
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner.	Completed		t's Education st grade completed)  College (1-4 or 5	+)	(Give k life. DC	ent's Usual Occup tind of work done of NOT use retired) Cashier	ation during most of wo	orking	16b. Kind	of Business Ret	,		
land 2	be filed w ental Hygi rked othe ic event, 1	To Be	17. Father's Name (First, Middle, L Charles	ast) Robe	rt		Barb	18. Mother's Nan	ame (First, Middle,	Maiden Sur Minery		Rigg]	Leman	
	d 2 should alth and M 27 is mai r traumat		19a. Informant's Name/Relationsh Judith Nave / I				,		ural Route Numbe yser, WV			c Code)		
Baltimore,	age 1 and ent of Hea nt: If item y or othe	البا	20a. Method of Disposition 1   Burial 2 □ Cremation 4 □ Donation 5 □ Other (S	3 ☐ Removal from State	C	emetery, crem	sition (Name of latory or other plac		Date / 2010		ation - City or			
Baltir	permit. P Departm Importar any injur		21. Signatule of Funeral Service	**	1 Sur	22	Name and Addres	ss of Facility A	/04/2010 dams Fam t, Cumbe	ily Fι	uneral		P.A.	
	Physician/ Medical		23a. Par 1. Enter the disease, or shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	complications that caused nly one cause on each line  a.  Due to (or as a		The	r the mode of dyin	g, such as cardia	c or respiratory an	rest,		Approximate Interval Bet Onset and	tween Death	
	Examiner	er	Sequentially list conditions,	b/	2m	1	ulin				year	~		
	cate be executed physician and s the burial-transit	edical Examiner	if any, leading to immediate cause. Eat of Johnson Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as a								•		
260	ate be e	dical		d										
Box 68	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as it.	Σ∣	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	23c. If yes, outcome of 1 Live Birth 2 Pregnant at g Unknown	2 🔲 Fetal	Ideath 3∟	Ectopic pregnance Other (specify)	у		230	d. Date of del Month	,	Year	
s, P.O.	ires that the signed by Id be detail	þ	Part II. Other significant conditio	ns contributing to death bu	ut not resu	ulting in the ur	nderlying cause giv	ren in Part I.				the cause of d		
Division of Vital Records,	he law requ te has beer age 2 shou	Completed								rmed?	prior to death?	topsy findings a	available ause of	
tal F	sian: Ti ertificat ctor, p		25. Was case referred to medical examiner?				26. Pl	ace of Death (Ch		2 - No	1 ⊔ Yes	s 2 □ No		
f Vii	Physic this ceral dire	욘	1 ☐ Yes 2 ☐ Ho  27. Manner of Death	Hospital:  1  Inpatie  28a. Date of injur		ER/Outpatient		4 LX Nursing	Home 5 Resid			ify)		
ion o	tending death. tor: After the funer	Certificate:	1 Natural 5 Pending 2 Accident Investig 3 Suicide 6 Could r	ation	Year)	injury			28d. Describe h					
Divis	oital or At		4  Homicide determi	ned 28e. Place of Injur building, etc.	(Specify)				28f. Location (S City or Tow	n, State)			er,	
	thin 24 hos	Medical	(Check 2 Medical Employers) 3 Certifying	Physician: To the best of r caminer: On the basis of ex Nurse Practioner: To the b	amination	and/or investi	gation, in my opinic eath occurred at the	n, death occurred time, date and p	at the time, date a lace, and due to the	nd place, an e cause(s) an	nd due to the o	cause(s) and ma stated.	nner stated.	
	2		29b. Signature and title of certifier	le ho			29c. License	17565			st 2,			
	nds		30. Name and address of person v Anthony J.	tho completed cause of de Bollino, Jr.	ath (Item , M.	23a) (Type, Pr D., 9	int) 22 Nation	nal High	way, LaV	ale,	MD 21	502		
	Stat	е	31. Date filed (Add CD) Year)	32. Registrar	's Signati	ure Anna	W.							

Registrar
DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 12, 6:40 a M Graciela Ester Alvarez-Flores 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/19/1976 9. Birthplace (State or Foreign Country)
EL Salvador 5. Social Security Number Funeral 1 □ M 2 🛣 F Hours Yrs. Director 644-03-6380 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🙀 No Director Maryland Prince George's Huattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8209 17th Avenue 20783 El Salvador Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Salvadorean 1 X Yes 2 □ No Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home Dermit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any injury or other 27 is marked other any injury or other 27 is marked 07 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fidel Alberto Flores ျှ Maria Ester Alvarez 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Miguel A. Hernandez - Spouse 17th Avenue, Hyattsville, Maryland 20783 8209 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) George Washington Cem 07/18/2010 | Adelphi, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Olo 11800 New Hampshire Ave., Silver Spring, MD 20904 implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) **Physician** ENDOMETRIAL CARCINOMA WITH METASTASIS /Medical Due to (or as a consequence of): Examiner SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 - Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Day Year 5 Other (specify) P.O. s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 L Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? s certificate has b irector, page 2 sh autopsy performed 1 ☐Yes 2 No 1 ☐Yes 2 ☐No To the Hospital or Attending Physiclan: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this c funeral dire 1 ☐ Inpatient 2 ★ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) BORIE JULY 20, 2010 D46324 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 CARROLL AVENUE, TOKOMA PACK, MARYLAND

DHMH 17 Rev 1/2001

State Registrar TERRY JUDGLE, MD, FACEP

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician RMIGER 1835 WINDSOR ,2010 achre Julu /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury Rehabilitation & Norsing Ctr. Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 M Months Days Hours 101 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Salisbury Nes 2 No Wicomico Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 23a or Village 21801 United Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 14. Race - American Indian 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 ☑No Specify: White Specify þ Baltimore, Maryland 21215-003 pe.mit. Pages 1 and 2 should be filed within 72 hours
Derartment of Health and Mantal Hygiene.
Im. ortant: If item 27 is marked other than "natural", am injury or other traumatic event, the Medical Exagon. 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) URIVER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be DINGSOR ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HAYMAN 28101 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City of Town, State ↑ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/24/2010 Shrist U. Meth. Charck 4 Donation 5 DOther (Specify) 22. Name and Address of Facility HINMAN Funeral Home; 21. Signature of Funeral Service Licensee Somerset AVE. PRINCESS ANNE MI 11673 MCC295 23a. 1. Enter the disease, or complications the aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause and line. Approximate Interval Between Onset and Death diate Cause (Final lange diate Cause (F ease or condition resulting in death) **Physician** 210 dec ear-/Medical Due to (or as a cons-Examiner 000 01 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 12 No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 5 ☐ Other (specify) detached 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ≦ 2 →No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s Sec autopsy performed? Yes 2 1210 certificate 1 ☐ Yes Division of Vital director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Descritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified

21804

Salisbury, MI

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W.D

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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Frances Beavers Marian 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Days Months Hours Min. 09-11-1922 Maryland Director 577-20-2186 87 Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12405 Madeley Lane 20715 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? 1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates Specify: white Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) switchboard operator 12 hospital and N.A.S.A. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Gugluizza Pasquala Messina Rosa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shannell S. Beavers Sycamore Terrace, Owings, MD 20736 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Ft. Lincoln Cemetery 07-30-2010 | Brentwood, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line respirato Immediate Cause (Final acidosis Physician/ disease or condition resulting in death) days Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Exami that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 Yes 2 No Month Day Year signed by the a Id be detached f 1 ☐ Yes ∠ J 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 124 hours after death. La hours after death. Liberal Director: After this certificate has been sign elect filled in by the funeral director, page 2 should be bed filled in by the funeral director, page 2 should be 3 Probably 4 ☐ Unknown 2 🗌 No 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Yes မြ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical

**Division of Vital** 24 hours a соmpleted To the I within 2 To the I

Box 68760

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Registrar

29a. Certifier

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(Check

only one)

29b. Signature and title of certifier

e of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

H065117

Monica Sounz D. &

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) July 24, 2010 **Physician** 4:32 a M Oliver Brown /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Calvert Memorial Hospital Calvert Prince Frederick If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days 1 M 2 F MD April 20, 1936 Director 578-44-4789 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at 1 Yes 2 No Director Calvert Huntingtown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20639 USA 705 Plum Point Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 \( \text{Yes} \) 2 \( \text{No} \) Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No 9 Specify 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Car Show Business Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emma Chase Warren Brown မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 705 Plum Point Road, Huntingtown, MD 20639 Vivian Brown - Personal Repre 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or o once, 1 KBurial 2 ☐ Cremation 3 ☐ Removal from State Patuxent UMC Cemetery July 29, 2010 | Huntingtown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sewell Funeral Home, P.A. 21. Signature of Funeral Service License Blades 1451 Dares Beach Rd., Prince Frederick, MD 20678 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Atherosclesot Cardio vas cular disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Cordio Vascular direase **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Die to (or as a consequence of): The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the as IF FEMALE: asn 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐Yes 2 ☐ No the Ö 9 Unknown 9 Unknown signed by the σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 Tyes 2 No 3 Probably 4 1 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed certificate 1 ☐ Yes 2 ☐ No 2 🗆 No 1 ☐ Yes After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1∐Yes 2☑No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital of within 24 hours a To the Funeral D Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 7-26-2010 50653 Jur con a SURANA GYAN C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State 31. Date filed (Month, Day, Year)
Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician JM14 26, 2010 Henry Leroy Burkman 1:10 P /Medical 4b. City, Town, or Location of Death Leonardtown 4a. Facility Name (If not institution, give street and number) 4c, County of Death Examiner St. Mary's Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) 12/16/1923 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 216-18-5389 1 X M 2 □ F Mary Land Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-1 show any injury or other traumatic event, I'm Micdical Examinar must be northing any once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Port Republic 1 ☐Yes 2 ☐No Calvert Director Maryland 10f. Zip Code 20676 10e. Street and Number 10g. Citizen of What Country? United States 2115 Parkers Creek Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🔏No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married white If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify 3 Midowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) agriculture farmer 18. Mother's Name (First, Middle, Maiden Surname) Katherine Rausch 17. Father's Name (First, Middle, Last) Be Henry William Burkman ပ 19b Mailing Address (Street and Number or Rural Route Appater, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print)
Marvin William Burkman— son 20b. Place of Disposition (Name of Christian Typis 2010) 20c. Location - City or Town, State Port Republic Maryland 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch, Funeral Home PA 4405 Broomes Is. Rd. Port Republic MD 20076 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CALDIORESPIRATON Physician /Medical Due to (or as a consequence of): Examiner HYPOMIA Sequentially list conditions, Due to (or as a consequence of) Physician/Medical Examiner if any, leading to inmedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last PNEUMONIA After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of) CONDESTIVE IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 2 No 3 Probably 4 Unknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division of Vital Records, P.O. Box 68760, drw

Baltimore, Maryland 21215-0036

State Registrar

Luit

29b. Signature and title of certifier

29c. License number 161693

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LEONMOITOWN

31. Date filed (Month, Day, Year)

32. Registrar Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** dilliam 10 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chevely FIRE Social Security Number 7. Age (In yrs. last birthday) Year If Uniter 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace State or Foreign Country). **Funeral** Months Days Hours 1 M 2 □ F Marzy 219-82-4670 50 Director 1960 12, Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It is Madical Examinar must be notified at 1 ☐Yes 2 ☐ No Prince **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number USA 20172 12. Was Decedent Ever in U.S. Armed Forces? 1 \( \text{Yes} \) 2 \( \text{No} \) Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🕱 No Be Completed by If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mar 1 2060 Hadley Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Mense 22. Name and Address of Facility 23a. Par 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Retu Immediate Cause (Final Physician disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and for use as the burial-tran Due to (or as a consequence of): physician Division of Vital Records, P.O. Box 68760. signed by the attending I IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗌 Ectopic pregnancy Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 □ No 1 □Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1. Tes 2 □ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Into Kica Fee 27. Manner of Death 5 Pending investigation 1 Natural face + STruck head 1808 July 20, 2010 1808 M 12

28e. Pace of njury - At home, farm, street, factory, office building, etc. (Specify) death. 1 Tyes 2 No 2 Accident after death 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Molly Berry Rural + VAN Brady Road water Marib determined 4 ☐ Homicide within 24 hours a 1 \( \) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ William . July 23, <sup>D</sup>2010 1:10am м Richard Bowers Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Marlboro Prince George's 10402 Beaver Knoll Drive If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 16 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 XM 2 1 F Hours Washington DO 56 Director 219 58 1955 1954 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Upper Marlboro 1 Yes 2 XX Mary1and Prince George's 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 10402 Beaver Knoll Drive 20772 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Forces þ 1 Never Married XX Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 XX Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Electrician Electrical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary McAllister Victor Bowers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10402 Beaver Knoll Drive, Upper Marlboro, MD 20772 Lila Bowers (Wife) 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory July 28, 2010 Clinton, Maryland 21. Signature of Funeral Service Censes 22. Name and Address of FacilityLee Funeral Home, inc 6633 01d Alexandria Ferry Road, Clinton, MD art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final caucer meras Ph sician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No g Unknown g 🗌 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1. Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27, Manner of Death 28a. Date of injury 28b. Time of 1 Natural 28c. Injury\_at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 5 Pending 1 Yes 2 No Investigation Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Lactifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License numbe 3 D042 049

DHMH 17 Rev 7/2009

Registrar

State

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30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JUL 28 2010

Champaloup MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene StateRegistrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 21, Day Physician/ Belida  $\operatorname{July}^{\mathsf{Month}}$ 11:25A. M Alexander James 201 gai Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Holy Cross Hospital Montgomery Social Security Number 9. Birthplace (State or Foreign Massachusetts 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 1 M 2 F 92 June 27, 1918 012-01-7816 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring Maryland Montgomery 1 🗆 Yes 2 🗀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3124 Gracefield Road, #218 20904 United States 12. Was Decedent Ever in U.S. Arraed Forces?

1 ⚠ Yes 2 ☐ No
If Yes, Give 1943–1965 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. <u>ک</u> 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: Completed 3 ☐ Widowed 4 ☐ Divorced permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Officer US Air Force Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Belida Vera Belinsky Demitry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 705 New Mark Esplanade Rockville, Maryland 20850 Alexander J. Belida, Jr. -son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Cem.9/30/2010 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia 21. Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, PA Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph sician/ Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Congestive Cardiomyopathy years Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law lequires that the death certificate be executed by hours of the death certificate be executed. weeks sate has keen signed by the attending physician and kage 2 should be detached for use as the burial-transit Pulmonary Edema Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Dav 2 🗌 No 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Atrial Fibrillation; Glaucoma; Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe To the Hospital or Attending Physician: he within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, gag. 1 Yes 2 No Yes 2 N 25. Was case referred to medical B B 26. Place of Death (Check only one) examiner? 2 No Hospital Other: 1 🗌 Yes မြ 1 Unpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 7/2009

State

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Burbara

31. Date filed (Month, Day, Year)

Barbara Supanich, MD HCH 1500 Forest Glen Road Silver Spring, Maryland 20910

D 0065485

07/21/2010

Suparuch RSM, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

	shua Ma- 0-05567	thi	as Brodsky Please Type or Print in Black Indelible Ink. Ensure All Copie	es Are Lec	ıible.	
t	<del>Jnk Unk</del>		State of Maryland / Department of Health and Mental H	ygiene		25151
\	Physici Medical Exam	ian/	1. Decedent's Name (First, Middle,Last)  Joshua Mathias BRODSKY	2. Date of Death	n Day Year	3. Time of Death 1334 hrs
2			4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death 3701 Howard Avenue  Kensington		4c. County of Death Montgomery	
10	Funeral Director		5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  1 Under 1 Year  1 Under 24Hrs  577 - 98 - 2186  1 M 2 F  44  Yrs.		h(MM/DD/YYYY) 9. Birt 21, 1966 Foreig	
	any	7	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	ıland f show an	tor	Maryland Montgomery Silver Spring			1 Yes 2 No
	th the Mary 23a or 28a potified at	I Director	10e. Street and Number 1220 East-West Highway, #1221 20910		g Citizen of What Coun United Sta	
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status  1 Never Married 2 Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year 1 1 Yes, Sive Year 1 Y		14. Race - Americ White, etc. Specify: Whi	
	hours aft "natural"	ted by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)   College (1-4 or 5+)   College (1-4 or		16b. Kind of Business/Ir	
	0036 within 72 iene. ner than	Completed	5+ Computer Scientist		Private	Industry
	21215-0036 Auld be filed within 7 Mental Hygiene. marked other than	Be C	110.0.0	ni Zinden	r	
	MD 21 nd 2 should alth and Me m 27 is ma	ပ္	19a. Informant's Name/Relationship (Type, Print)  Harold Brodsky, Father  19b. Mailing Address (Street and Number or F 1411 Whittier St., NW,			Zip Code) 0012
	Nore, I		20a. Method of Disposition  1 X Burial 2 Cremation 3 X Removal from State Ohev Sholom Cemetery 08/	Date '05/10	20c. Location - City or Washington	
	Baltimore, permit. Pages 1 as Department of He Important: If ite		21. Signature of Finer I Service Licensee	uneral	Home	
	<i>Y</i> Physician		23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.	washii r respiratory arre	ngton, DC st, shock, or heart	20012 Approximate Interval Between Onset and
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Multiple blunt force injuries  Due to (or as a consequence of):			Death
		iner	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):  Due to (or as a consequence of):			
	ited d ansit	Examiner	(Disease or injury that initiated events resulting in death) Last  C:  Due to (or as a consequence of):			71
	0, be execute sician and burial - tran	edical	X UNPENDED AMENDED 23a,27,28a-f, per ME G907 9/23/10	ΓT		
	Division of Vital Records, P.O. Box 68760, within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - tran	siciar	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown 1 Unknown 2 No 9 Unknown 2 Unknown 2 Unknown 2 Unknown 3 Ectopic pregnant at time of death 5 Other (Specify)	ncy	23d. Date of delivery Month D	ay Year
	O. Bc at the dea d by the a	된	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	pacco use contribute to t	he cause of death?
	ds, P. equires the een signer ould be de	eted by		1 Yes	2 No 3 Prob	ably 4 Unknown opsy findings available
	Division of Vital Records, P.O. Box the Hospital or Attending Physician: The law requires that the death hin 24 hours after death.  the Funeral Director: After this certificate has been signed by the attempletely filled in by the funeral director, page 2 should be detached for up	Completed		autops perform 1 Yes 2	ned? death?	ompletion of cause of
	Vital hysician this certi	To Be	25. Was case referred to medical examiner?  1 V Yes 2 No  Check 0  ER/Outpatient 3 DOA  Other Nursin		Residence 6 🗸 Other:	Scene
	on of ending P ath. or: After the funera		27. Manner of Death  1 Natural 5 Pending Fd 7/25/10 Fd 1317 hrs 1 Yes 2 No		struck by	train
	Division  Hospital or Attend 24 hours after death. Funeral Director:	Certification:	Z   X   Accident Investigation I	28f. Location (St or Town, Sta Kensing	reet and Number or Rurate) 3701 Howa	al Route Number, City and Ave
	To the Hospi within 24 hou To the Funer completely fil	Medical Co	29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one)  2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.	due to the cause	(s) and manner as state	d.
	To To con	Me	29b. Signature and title of certifier  29c. License number  O.C.M.E.		29d. Date signed (Mon July 26, 2010	th, Day, Year)
		-	30. Name and address of person who completed cause of death (Item 23a)  Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MI	L D 21201		
	Si Regis	tate	31. Date filed (Month, Day Year)  AUG 06 2010 32 Registrar's Signature			
	regis	di ti	MUU V - LOTE			

10-05024 Carol Blackshear Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 2010 25152 State of Maryland / Department of Health and Mental Hygiene

	1- For State Certifica	te of Death	Reg. N					
Physician/ Medical Examine	1. Decedent's Name (First, Middle, Last)		2. Date of Death  Month Day  July 5, 2010	3. Time of Death 0004 hrs				
	Facility Name (if not institution, give street and number)     Penninsula Regional Medical Center	4c. County of Death Wicomico						
Funeral Director	5. Social Security Number 156-52-8216  1 M 2 X F  53 Yrs.  1 If Under 1 Year If Under 24Hrs. Months Days Hours Min.  Mar 12,1957  8. Date of Birth (MM/DD/YYYY) 9. Birth Foreign Countries of the control							
ом алу	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town of Decedent  10c. City, Town of Decedent  10c. City, Town of Decedent			10d. Inside City Limits 1 X Yes 2 No				
ith the Maryland 23a or 28a-f show any notified at once. al Director	10e. Street and Number 12920 Alex Avenue	10f. Zip Code 19956	10g. C	Citizen of What Country?				
er death w , or items r.must be Funer	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, I		14. Race - American Indian, Black, White, etc.  Specify: White				
5-0036 led within 72 hours afth Hygiene other than "natural" the Medical Examine Completed by	or Dates:	Decedent's Usual Occupation (Give ki luring most of working life. DO NOT u		o. Kind of Business/Industry				
21215-0036 uld be filed within 7 Mental Hygiene marked other that c event, the Media	D. Wayne McGrath	Lorra	Name (First, Middle, Maid yne Kinnane					
MD 2121: nd 2 should be fil alth and Mental I: nn 27 is marked raumatic event,	Page 19a. Informant's Name/Relationship (Type, Print)  Corinda Harmon/daughter  12	Mailing Address (Street and Numb 2920 Alex Ave., L	aurel, DE 19	956				
0, 8 9 3 E	4 Rurial 2 X Cremation 3 Removal from State cremato	f Disposition (Name of cemetery, bry or other place) OURY CREMATORY		c. Location - City or Town, State Salisbury, MD				
Balt permit. Departi Import injury	21. Signature of Funeral Service Licensee  21. Signature of Funeral Service Licensee  22. Signature of Funeral Service Licensee  23. Part I. Enter the disease, or complications that caused the death. Do no	22. Name and Address of Facility Lewis N. Watso 1618 West Rd.,	n Funeral Ho Salisbury, M	me, PA D 21801 shock, or heart   Approximate Interval				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do no failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	done intoxication	1	Between Onset and Death				
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uted d ansit Examiner	u.							
760, icate be executed physician and the bunal - transit	AMENDED AMENDED AMENDED, 27,28a-f,p	er ME g906 8/18/		23d. Date of delivery				
Box 68760, e death certificate be the attending physic of for use as the burbursician/Mec	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 4 Pregnant at time of death 5			Month Day Year				
, P.O. Bc res that the des signed by the z be detached fo	वे	g in the underlying cause given in Par		co use contribute to the cause of death?				
ords aw requi			24a. Was an autopsy performed					
Vital Rec ysician: The l his certificate b director, page	25. Was case referred to medical examiner?	26.Place of Death ( utpatient 3 DOA Other		sidence 6 Other:				
on of Vi nding Physi th. T: After this re funeral dii		Time of Injury 28c. Injury at Work?		injury occurred				
Division o spital or Attending sours after death. neral Director: After filled in by the fune	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  Accident Investigation 28e. Place of Injury - At home, far (Specify)	arm, street, factory, office building, etc	28f. Location (Stree or Town, State K-4 Salis	et and Number or Rural Route Number, City ) 304 Glenn Ave Apt bury, MD				
Division of  To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After t completely filled in by the funeral		nvestigation, in my opinion, death occ	curred at the time, date and	place, and due to the cause(s)				
F & F & B	29b. Signature and title of certifier  Manyera The Hull	29c. License number O.C.M.E.		ad. Date signed (Month, Day, Year)				
	30. Name and address of person who completed cause of death (Item 23a)  Margarita Korell MD. Assistant Medical Examiner	111 Penn Street, Baltimore	, MD 21201					
Stat Registra	te 31. Date filed (Month, Day, Year) 3 Registrar's Signature	harl						

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Layerne S. Cross July 26, 2010 04:45 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Allegany Frostburg Village Nursing Care Center Frostburg Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Months Days Hours Min. December 07, 1914 West Virginia <u>578-30-7377</u> Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 Yes 2 □ No Frostburg Maryland Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29 Beall's Lane Funeral U.S.A. 21532-12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) education teacher 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Patrick Stanton Catherine Connelly 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia 22153-Ann Applegate daughter 8489 Summer Breeze Springfield 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cumberland Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory July 28, 2010 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part . Enter the disease, or complications that caused the death. Mock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final DVANCED disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events Que to (or as a consequence of) Exami Physician/Medical

**Physician** /Medical Examiner

**Funeral** 

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Eventine Least be notified at once.

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar attending physician for use as the buria the detached signed by I director, page 2 should has been certificate

Division of Vital Records, P.O. Box 68760,

þ Completed Be Certification: To After this funeral within 24 hours after death

To the Funeral Director:
completely filled in by the

cal Medi

29b. Signature and title of certifier

Hallon

Didhu 28 2010

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

Registrar's Signatur

resulting in death) Last	Due to (or as a consequence of):	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause	of death?
NORMAL	PRESSURE 140RUCEPHALLE 1 - Yes 2 No 3 - Probably 4	Inknown
	24a. Was an autopsy finding prior to completion death?  1 □ Yes 2 □ No 1 □ Yes 2 □ No	of cause of
25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 Yes 2 No	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: Nursing Home 5   Residence 6   Other (Specify)	
27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)   28d. Injury at Work?   28d. Describe how injury occurred	
3 ☐ Suicide 6 ☐ Could not determined		Number,
29a. Certifier 1 Check only one) 1 Certifying F	hysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  miner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cau and manner stated.	ıse(s)

29c. License number

29d. Date signed (Month, Day, Year)

umbercavid MD

DHMH 17 Rev 1/2001

TILS

State Registrar

death.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>010</u> Physician/ Month A M 5:00 Betty Virginia Drury Ju<sub>1</sub>v 29 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Hospital Hagerstown Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov. 17 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours **Director** 80 1929 212-24-5869 Marvland Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Examiner must be notified at Director 1 XYes 2 🗌 No Hagerstown MD Washington 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ō items 23a 367-B Woodpoint Ave. 21740 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Black. White, etc. "natural", or 1 Yes 2 No If Yes, Give Year or Dates. δ 1 Never Married 2 Married 21215-0036 1 Tes 2 No Specify. Specify: White Completed 3 Widowed 4 ☐ Divorced traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker 6 Domestic Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ڡ Frank Milton McCarney Helen Pauline Everly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita Dawson / Daughter 3265 State Line Rd., Waynesboro, PA 17268 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) any injury or 7/31/2010 Hagerstown, Maryland Rest Haven Cemetery 22. Name and Address of Facility Signato of Funeral Serv Rest Haven Funeral Chapel 601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each Interval Between Onset and Death Immediate Cause (Final Physician/ 2~11 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examin attending physician and for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the a d be detached f 1 Yes 2 kg Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed has death? 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I **Division of Vital** 25. Was case referred to rhedical 26. Place of Death (Check only one, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Medical Examiner: On the basis of Certifying Nurse Practioner: To he best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. opty one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) tarne and address of person who completed cause of death (Item 23a) (Type, Print) my 11111 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State	of Marylan		artment of ctificate o				0	010	251	56
			Registrar  1. Decedent's Name (First, Middle	(ast)		Cer	uncate of	Deal		2. Date of De	Reg. No.	010	3. Time	
	Physicia	an								Month July	Day 21	Year 2010		M
	/Medic							or Location	on of Death	July		ounty of Deal		) a
	Examin	ier	8100 Connection					y Cha				ontgome		
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Yea	r If Und	der 24 Hrs.	8. Date of Bir (Month, Di	rth	9. Bir	hplace (State	or Foreign
	Director		112-28-3100	1 □ M 2 🖾 F	8	6 Yrs.	Months Day	s Hour	S IVIIII.	June 2	5 192	4	Chi	1e
	w and		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside (	City Limits
	f sho	ō												s 2⊠No
	the N	rect	MD Mont  10e. Street and Number	gomery	CII	evy Ch	10f. Zip Code				10g. Citize	en of What Co	untry?	
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	death	Funeral Director	11. Marital Status	12. Was Dec	cedent Ever in U.	S. 13.	Nas Decedent o f Yes, specify Cu	f Hispanic	Origin? (Sp	ecify Yes or No	D- 14	I. Race - Ame		
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9500-61212	be flied within 72 hours after death with the Marylan rital Hygiene. And Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Madical Examinar must be notified at	ed by	3 ☑ Widowed 4 ☐ Divorced	Year or	Dates:	160 Dece	dent's Usual Occ	unation				of Business	Whit	e
<u>က်</u>	n 72 n "nai	Completed	15. Decedent (Specify only highes	t grade completed		(Give	kind of work dor DO NOT use reti	upalion e during n red)	nost of work	ing	TOD. KITC	J OI Busilless/	maustry	
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ב פ	othe othe vent,	BeC	17. Father's Name (First, Middle,	Last)				1	other's Name	e (First, Middle				
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Mary	12 should be filled who and Mental Hygie is marked other traumatic event, the	0 1	19a. Informant's Name/Relationsh	nip (Type. Print)		T	ng Address (Stre							
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0	iges 1 toff iffite or ot		20a. Method of Disposition 1 ☐ Burial 2 ★ Cremation		State		sition (Name of natory or other p		!	Date		,		_
altimor	iff. Partitude ortant ortant ortant		4 □ Donation 5 □ Other (S <sub>k</sub> 21. Signature of Funeral Service I		M014	Linc	oln Cres	nator	y //29	/2010   mple Ti	Brent	wood,	Maryla	nd
n D	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic evonce.	di s	21. Signature pri rumani Sarvice	licerisee	H014		040 Rock						0852	
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מ ה	he att	sicis	in the past 12 months? 1 □ Yes 2 No		gnant at time of c		Other (specify)			<del></del>		Month	Day	Year
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Vital	tificat or, pa		25. Was case referred to medical	1-				26 PI	ace of Deat	1 □Yes	25	1 ∐Yes	2 ☐No	
<b>&gt;</b>	ysicia is cer direct	o Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1	Inpatient 2	ER/Outpatier	nt 3 DOA	thor:		ome 5 😡 Res		□Other (Spe	ecify)	
VISION OF	ig ru fer th neral	T:UC	27. Manner of Death 1 ☐ Natural 5 ☐ Pending		e of Injury nth, Day, Year)	28b. Time of Injury	28c. In			28d. Describe				
	eath. or; A	catic	2 Accident investig	ation			M 1	□Yes 2	□No					
	fter d fter d jrect in by i	Certification: To	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	ned 28e. Plac	e of Injury - At ho ding, etc. <i>(Specif</i>	ome, farm, str fy)	eet, factory, offic	e		28f. Location ( City or To	(Street and wn, State)	Number or R	ural Route Nu	ımber,
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100	within 24 hours after death.  To the Tourus after death.  To the Furneral Director: After this certificate has been signed by the attending to completely filled in by the funeral director, page 2 should be detached for use as	Medical		Examiner: On the										e(s)
Ę.	within within comp	Me	29b. Signature and title of certifier	ſ.			29c. Lice	nse numb	er		29d. Date	signed (Mon	th, Day, Year)	
	5		) Trong	5 /1/ LES	v v	~>	D552	258			July	22, 20	10	
			30. Name and address of person				Print)							
			Gary B. Wilks 31. Date filed (Month, Day, Year)					Bet	hesda	, MD 20	814			
	Sta Registr	_	JUL 28 2	010 6	Registrar's Signa	bau	co.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 25157 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 Lyla Fallon 5:25 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛚 F Days Months Hours Min. 12/12/1924 219-20-6330 Director 85 Jsual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Harford Fallston 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3037 Bellechasse Road 21047 United States 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in LLS 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: Completed White Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'amy injury or other traumatic event, the Mea. ONCE. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Clerical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Rittenhouse Claudia Ball 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paula Mauldin - Niece <u>3037 Bellechasse Rd.</u> Fallston, MD 21047 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Lakeview Mem. Park 7/30/10 4 ☐ Donation 5 ☐ Other (Specify) Eldersburg, MD Feral Sarvia Licensee 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc 21. Signature M01411 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ RESPIRATORY 1445 Medical resulting in death) Examiner NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events the burial-transi and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months? Year 4 Pregnant at time of death 9 Unknown Yes 2 No 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by EMPHY SEMA 1 X Yes 2 No 3 Probably 4 Unknown ISCHEMIC CARDIOMYOPATHY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ATRIAL FIBRILLATION has ' CORONARY ARTERY DISEASE performe this certificate 2 No 1 Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: Certificate: To 1 ☐ Yes 2 AcNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🕱 Other (Specify) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 Natural 5 Pending 1 🗆 Yes 2 🗆 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in my state of the cause of examination and/or investigation in my state. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of co D64395 JULY 24,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIEUL DEBERMAN, MO 6701 N BHARIES ST, SUITE 4105 BALTIMENE, MD 21204

State

Registrar

31. Date filed (Month, Day Year)

back

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician 1900 John O. Ford 24 ,2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury Rehabilitation + Nursing Ctr. Wicomico Salisbury If Under 1 Year | If Under 24 Hrs 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 **X** M 2 □ F 220-28-0203 Director June 10, 1932 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo MD Wicomico Delmar 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 9345 Rum Ridge Road 21875 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. Armed Folces:
1 ⊠ Yes 2 □ No
If Yes, Give
Year or Dates: Korean 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🔀 No Specify: þ white Baltimore, Maryland 21215-003 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 <u>Panel Board Operator</u> Nylon Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Oscar Ford Mildred McDaniel ပ 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma Lee Ford (Wife) 9345 Rum Ridge Road Delmar, MD 21875 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Stephens Cemetery July 28, 2010 Delmar, Delaware 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Short Funeral Home 13 East Grove Street Delmar, DE of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. 23a. Part1. Enter the disease shock, or hear fail ire. I Immediate Cause disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Cleate Firing) that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t Part II. Other significant/conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform this certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 x certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

State Registrar

taulette 31. Date filed (Month, Day, Year) JUL 28 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

ivic Ave. Salisbury, M.D. 21804

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month JREENWELL 0600 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Mandrin Chesapeake Hospice House Harwood Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 M Days Min. Hours 11-05-1925 Mary I and Director 214-24-1818 84 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Anne Arundel Lothian 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1416 Wrighton Road 20711 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 🕅 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 27 is marked other than "natural", traumatic event, the Medical Exar Specify. 3 X Widowed 4 Divorced white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 editorial & cartographic clerk US Census Bureau Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) and Mental ဂ္ Wilbur McFarland Bess 1 and 2 should be of Health and Meritem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to Debra G. Chaney, daughter 1407 Wrighton Road, Lothian, MD 20711 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Friendship Cemetery 08-02-2010 Friendship, MD Signature of Typeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ongestive month disease or condition resulting in death) Medical Due to (or as a lonsequence of) Examiner Sequentially list conditions. Examine day, leading to immediate cause. Enter Underlying Cause (Disease or linjury Sue to (or as a consequence of) that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) g physician a Physician/Medical Box 68760 attending pl IF FEMALE f yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes No
9 Unknown Month Pregnant at time of death signed by the a d be detached f g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by FIBRILL ATION Records, 2 No 3 Probably 4 Winknown been signated the 24b. Were autopsy findings available 24a. Was an Jas autopsy performe prior to completion of cause of page 2 this certificate Yes 2 🗷 1 Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify Hospital 1 🗌 Yes 2 **X**No မ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Physwithin 24 hours after death.

To the Funeral Director, After this completed filled in by the funeral di 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending Accident 2 🗌 No 1 Tyes Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature nd title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** hristopher 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign . Age (In vrs. last birthday) 5. Social Security Number **Funeral** 1 🟋 M 2 🗆 F Hours Yrs Michigan 01-27-1983 27 Director 369-92-0636 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show must be notified at 1 ☐ Yes 2 🔀 No Director MD Baltimore Halethorpe 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code þ Items 23a 909 Elm Road 21227 USA by Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iter any injury or other traumatic event, the Medical Examiner once. 1 X Never Married 2 ☐ Married Pages 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Information Technology System Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Griffith Tricsli Eva Marie Leslie Α. ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Eva M. Griffith, 263 Greenridge Drive, Dunkirk, MD mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 07-28-10 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licensee 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis **Physician** disease or condition resulting in death) /Medical Due to or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or in Jury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) Box 68760, physician Physician/Medical the as IF FEMALE: asn 23c. If yes, outcome of pregnancy 23d, Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 🗌 Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death
☐ Unknown Month Day Year 5 Other (specify) 1 Yes 2 9 Unknown 2 □ No P.O. by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records. 2 No 3 Probably 1 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed' 2 No 2 🗌 No or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) completely filled in by the funeral director, Be examiner?
1 \( \sum \) Yes \( 2 \sum \) No Hospital: 1 VInpatient Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 2 ER/Outpatient 3 🗌 DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 5 Pending investigation 1 Yes 2 No after death. Director: Aft 2 Accident 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Hospital 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

drw 10

within 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUSAN QUAN

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

(check only

one)

32. Registras Signature backer

Medical

State

Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 23 2010 ea 12:22p M Carole Ann Graham Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery 13501 Collingwood Terrace Silver Spring | If Under 1 Year | If Under 24 Hrs. 8. Date of Birth | Months | Days | Hours | Min. | March | U7 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 M 2 X Pennsylvania Director 216-40-9051 68 Usual Residence of Decedent 28a-f shov ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13501 Collingwood Terrace 20904 U.S.A. death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces Black, White, etc. þ 1 Never Married 2 X Married ☐ Yes 2 🗶 No 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: and Mental Hygiene. If Yes, Give 3 
Widowed 4 Divorced Completed Year or Dates White traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Mildred Frick Elmer E. Hershberger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health a item 27 Malcolm Graham - Spouse 13501 Collingwood Terrace, Silver Spring, MD 20904 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Parklawn Memorial Pk. 07/30/2010 Rockville, Maryland 4 Donation 5 Other (Specify) uneral Service Licena 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician/ Pancreatic Carcinoma disease or condition Months Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 X No Month Year Pregnant at time of death Day been signed by the should be detached a Hinknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1  $\square$  Yes 2  $\boxtimes$  No 3  $\square$  Probably 4  $\square$  Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 performed 1 Yes 2 No Yes 2 X No 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner' Hospital: Other: 1 Tyes 2 🗶 No 읻 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) uneral Director: After the dilled in by the 6... 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 10 D39979 July 27, 2010 30. Name and address of person who com pleted cause of death (Item 23a) (Type, Print)

State

Registrar

William King Kell

28

31. Date filed (Month, Day, Year)

MD.

1400 Forest Glen Road, #435, Silver Spring, MD 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month William Bigelow Hoey, Jr. July 2010 1638 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Allegany Flintstone Volunteer Fire Departmen Flintstone Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) 04/18/1932 Country) Ohio 78 Director 373-32-1659 Usual Residence of Decedent Show 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f shor Examiner must be notified at 10d. Inside City Limits the Maryland Director DE Sussex I.ewes 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 21088 Emerald Isle Drive 19958 USA 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 No
If Yes, Give Korean
Year or Dates. Fra þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: "natural", 3 □ Widowed 4 □ Divorced Completed White er than "natura the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Manufacturing Sales/Marketing 27 is marked other traumatic event, th Be Page 1 and 2 should be filed iment of Health and Mental Hyy tant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Bigelow Hoey, Sr. 01ga Elizabeth McVev William 19a. Informant's Name/Relationship (Type, Print) 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robbin L. Comiski / Daughter 664 Danbury Court, Newtown, PA permit. Page 1 and 2: Department of Health Important: If item 27 any Injury or other tronce. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State Cumberland Crematory 07/26/2010 4 ☐ Donation 5 ☐ Other (Specify) Cumberland, MD 22. Name and Address of Facility Adams Family Funeral Home, 21. Si na ure if Funeral Sefvice Liesnsee 404 Decatur Street, Cumberland, 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Arteriosclerotic Heart Disease disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or iinjury the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical requires that the death certificate be P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 5 Other (specify) Yes detached the g Unknown q 🗍 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an page 2 autopsy Yes 2 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Fire Department Hospital: Other: 1 X Yes 2 🗆 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Nother (Spec 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred

Division of Vital Records, Hospital or Attending Physician; The law After this certificate neral Director: A To the Hospital within 24 hours a To the Funeral Completed filled

101 nes

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Paul Snow, M.D., 124 West Third Street, Cumberland, Maryland 31. Date filed (Month, Day, Year)

26 2010

5 Pending

Investigation 6 ☐ Could not be

determined

1 💹 Natural

2 Accident
3 Suicide

4 Homicide

29a. Certifier

(Check only one

29b. Signature and title of certifie

JUL

32. Registrar's Signature artes

Registrar

State

injury

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Physician: to the best of my knowledge, death occurred at the time, date and place, and due to the rease(s) and due to the cause(s) and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D09157

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year)

July 26, 2010

City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			_ FUI	ertificate of Death	Reg. No. 25   63		
10	Physici /Medic		1. Decedent's Name (First, Middle, Last)	2. Date of D Month	Day Year 0915 AM		
	Examin		4a. Facility Name (If no institution, give street and jumber)  Anne Arundel Medical Center	4b. City, Town, or Location of Death Annapolis	4c. County of Death Anne Arundel		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday $578-34-9267$ 1202M $2\square$ F 81 Yrs.	y) If Under 1 Year If Under 24 Hrs.   8. Date of B   Months   Days   Hours   Min.   08/24/	9. Birthplace (State or Foreign Country) DC		
	/land		Usual Residence of Decedent  10a. State	ocation	10d. Inside City Limits		
	Ba-fsh	Director	MD Calvert Sunder		1 ☐ Yes 2 No		
	with th	I Dire	10e. Street and Number 5110 Sunny Hill Drive	10f. Zip Code 20689	10g. Citizen of What Country? U.S.A.		
980	be filed within 72 hours after death with the Maryland that Hyglene. dother than "natural", or ftems 23a or 28a-f show event, the Medical Examiner must be redified at	by Funeral			No- 14. Race - American Indian, Black, White, etc.  Specify: White		
21215-0036	"natur	Completed	15. Decedent's Education (Specify only highest grade completed) (Given the	edent's Usual Occupation re kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry		
212	d withir giene. sr than	omp		neyman Book Binder	Printing		
/land	e d at e	To Be C	17. Father's Name (First, Middle, Last) Edward James Haley	18. Mother's Name (First, Middl Carmen Karout			
, Mar	od 2 s ulth ar 27 is r trau	•	Pearl Haley/Wife 5110	Sunny Hill Drive, Sunder	rland, MD 20689		
Baltimore, Maryland	permit. Pages 1 at Department of Hes Important: If item any Injury or othe ODCE.		4 Donation 5 Other (Specify)				
Ball	permit Depari Impori any In			22. Name and Address of Facility Lee Funera $8125$ Southern Md Blvd., (			
May .	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	nter the mode of dying, such a cardiac or respiratory	arrest, Approximate Interval Between Onset and Death		
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):				
	cuted on on one of the other one of the	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
68760,	icate be executed physician and the burial-transit	edical Exa	cal Exa	cal Exar	resulting in death) Last  Due to (or as a consequence of):  d.		
	ertifica ling ph e as th		IF FEMALE:				
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bagge 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant 1 Live birth 2 Fetal death 3	B ⊟Ectopic pregnancy □ Other (specify)	23d. Date of delivery  Month Day Year .		
rds, P.	w requires that been signed to should be deta		Part II. Other significant conditions contributing to death but not resulting in the	1	d tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4		
Vital Records,		Completed by		24a. Wa aut per 1 □ Yes	topsy prior to completion of cause of death?		
Vita	slcfan: The certificate irector, pag	Be	25. Was case referred to medical examiner?  1   Yes 2   No	26. Place of Death (Check only			
on of	or Attending Physician: after death. Director: After this certific in by the funeral director, i	tion: To	27. Manner of Death  1 Natural 5 Pending (Month, Day, Year)  2 Accident investigation	of 28c. Injury at 28d. Describe	sidence 6 ☐Other (Specify) e how injury occurred		
Division	al or Attendi safter death. I Director: A id in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office 28f. Location City or T	(Street and Number or Rural Route Number, own, State)		
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	Medical C	29a. Certifier (Check only one)  CertifyIng Physician: To the best of my knowledge, der (Check only one)  CertifyIng Physician: To the best of my knowledge, der and manner stated.				
	To the within 2 To the comple	M	29b. Signature and the occertifier	29c. License number 8/6376	29d. Date signed (Monfn, Day, Year) 7/2-7/10		
de	W 15		30. Name and corress of person who completed cause of death (Item 23a) (Type	cal Navy Amago	29d. Date signed (Month, Day, Year) 7/27/10  olis MD 2140/		
	Sta Registi		31. Date file (Month, Day, Year)  32. Registrate Signature  JUL 28 2010 Annua A	back			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 28  $\operatorname{July}^{\mathsf{Month}}$ 2010 Joan Mildred Howard 03:36 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Riva 3040 Pike Drive . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2**X**□ F 215-36-4962 Days Hours 07/37/74939 Washington,D.C. Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 🗆 Yes 2 💆 No Marvland Anne Arundel Riva 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a United States 21140 408 Porpoise Lane death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black White etc. ģ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after If Yes Give 1 ☐ Yes 2 🛣 No Specify Specify. White Completed 3 V Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 l n and Mental Hygiene. 7 is marked other than "r Schoo1 Flementary/Seconday (0-12) College (1-4 or 5+) 12 Bus Aide Transportation other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mildred Elizabeth Kelly should be Calvert Grant Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shu Department of Health an Important: If item 27 is any injury or other trau 3040 Pike Drive, Riva, Maryland 21140 Marlene E. Mueller/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Lakemont Memorial Gardens 107/30/2010 Davidsonville, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home Funeral Service Licensee 21. Signatur 2973 Solomons Island Road, Edgewater, MD 21037 al at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Par 1. Enter the disease, or complications to shock, or heart failure. List only one cause of complications th Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that the death certificate be executed attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Vear 5 Other (specify) Pregnant at time of death the 9 Unknown Division of Vital Records, P.O. signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires the within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be 2 □ No 3 □ Probably 4 🗡 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 2 🗆 No 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? DRUGATER'S Hank 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature nd title of certifier 29d. Date signed (Month, Day, Year) 201 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 445 Defense Highway, Krieger, Annapolis, Maryland 21401 31. Date filed (Month)

DHMH 17 Rev 7/2009

State Registrar 727 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 11:04 AM 2010 Genevieve Elizabeth HURD Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hagerstown Washington Washington County Hospital If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** 1 🗆 M 2 🛚 F Months Hours Min. (Month, Day, 1933 Maryland Director 217-28-5992 77 May be filed within /2 II-CL. Antal Hygiene.
arked other than "natural", or items 23a or 28a-f show arked other than "natural", or items 23a or 28a-f show arke event, the Medical Examiner must be notified at Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Hagerstown Maryland Washington 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral USA 21740 16900 Lakeview Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 Yes 2 No Black, White, etc. 1 Never Married 2 Married \$ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify 3 X Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Her own home Homemaker permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Mercle Gaither Miller Gess 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16900 Lakeview Court, Hagerstown, Md. 21740 Kitty E. Lynn - Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🗆 Burial 2 🗓 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) Hagerstown Crematory 7/30/2010 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home filed B Kon 415 E. Wilson Blvd, Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Terebroloscular prident Immediate Cause (Final Physician/ disease or condition Medical resulting in death) 7 days Examiner Esquentiary liet ecreticine, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury death certificate be executed physician and s the burial-transit ronary that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 ası 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IE EEMALE 23d, Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown jo Month Year Day 9 Unknown the P.O. by s been signed b Part II. Other significant conditions contributing to death but not resoluting in in an inderlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, ortie Shenosis - replacement 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has ; page 2 s autopsy performe To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h 1 Yes 2 No 2 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No Natural 5 Pending injury Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined Medical 29a. Certifier 🗜 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number D 27898 29d. Date signed (Month, Day, Year)

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State

350 MILL ST. HAGERSTOWN, MD 21746

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

AMORADE

Registrar's Signatu

2NAN OUSCO

10-05657 Adrian M. Hartman Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Adrian M. Hartmar	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar  Certificate of Death Reg. No. 2010	25166
Physician Medical Examine	A D C - a Month Day Year	ime of Death 1517 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 13423 Ellerslie Road Cumberland Allegany	
Funeral Director	5. Social Security Number 229-06-2101  6. Sex 17. Age (In yrs. last birthday) 1 Months Days Hours Min.  6. Sex 17. Age (In yrs. last birthday) 1 Months Days Hours Min.  1 - 27 - 1975  Foreign Country	VA
Maryland 28a-f show any 1 at once.	7	I. Inside City Limits Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15545 USA	
ter death with i	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American I White, etc. 15. Was Decedent Ever in U.S. 16. Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. Yes, specify: White, etc.	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland hard Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she unatic event, the Medical Examiner must be notified at once	10 Dates.	stry
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than c event, the Medica	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)  19. HARTMAN  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip	
MD 21 ad 2 should alth and Mer am 27 is man	JOHN D. HARTMAN / FATHER 3 KINGS GROVE RO HYNOMAN PA 15545	
Baltimore, MD 2121 permit. Pages I and 2 should be fi Department of Heatth and Mental I Important: If item 27 is marked injury or other traumatic event,	20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State  4 ☐ Donation 5 ☐ Other Specify:  20b. Place of Disposition (Name of cemetery, crematory or other place)  COOKS CEMETER Y  20c. Location - City or Town crematory or other place)  Wellers burg  21. Signature of Funeral Service Licensee  22. Name and Address of Facility HARVEY H. ZEIGLER FUN	, PA
	CHUMY W. THUTCH HOME INC 169 CLARENCE ST HYNOMA	N PA 15545
Physician Medical Examiner		pproximate Interval etween Onset and Death
Zammer	or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.	
ted Insit	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated	
	events resulting in death) Last Due to (or as a consequence of):  d.	
60, ate be execu hysician and te burial - tra	UNPENDED AMENDED  IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery	
). Box 6876, the death certificate by the attending phy ched for use as the Physician/M.	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Pregnant at time of death 5 Other (Specify) 9 Unknown	Year
P.O.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of the ca	
cords law requi	24a. Was an autopsy performed?  1 ✓ Yes 2 No 1 ✓ Yes	y findings available letion of cause of
Vital Relativistician: The this certificate	25. Was case referred to medical examiner? 1 Ves 2 No   26. Place of Death (Check only one)  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other Other Sce	ne
ion of \\ icending Phy leath.  tor: After th the funeral of	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation  28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1510 hrs 1 Yes 2 No  Priver auto auto collision	
Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 4 Homicide (Specify) Local Street 28f. Location (Street and Number or Rural Report of Town, State) 13423 Ellerslie Road, Cumberland, MD	oute Number, City
To the Ho within 24 To the Fu completely	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cau and manner stated.	ise(s)
7	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, D	ay, Year)
nas	30. Name and address of person who completed cause of death (Item 23a)  Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Stat Registra		

DHMH 17 Rev 1/2001 OCME 2006

DOME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Margaret Harless Month July 25, 2010 Year 22:57 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Allegany Frostburg Village Nursing Care Center Frostburg 5. Social Security Number 6. Sex If Under 1 Year I If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days 1 M 2 M F December (8") 1930 Perinsylvania 217-28-2331 Director Usual Residence of Decedent 28a-f show 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Examiner must be notified at Director Maryland Allegany Frostburg 1 X Yes 2 ☐ No 5 10e. Street and Number 53 Ormond Street 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a U.S.A. 21532-12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ö þ 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 72 hours after າer than "natural", ເ ;, the Medical Exam 1 ☐ Yes 2 No Specify: Specify: White 3 ₩ Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) artment of Health and Mental Hygiene. ortant: If item 27 is marked other than injury or other traumatic event, the Me 6 College (1-4 or 5+) Elementary/Seconday (0-12) education teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Julius Michael Edna Baer permit. Page 1 and 2 should to Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Michael Sister-in-law 21532-201 East Street Frostburg Maryland 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
Finzel Cemetery July 30, 2010 Frostburg Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licen 22. Name and Address of Facility any Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 ollu . Bart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ 1etaStATic RUNUMA of UNKNOWNOBA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine pue là lor às à consequence on Hospital or Attending Physician; The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy Month Day Year Pregnant at time of death signed by the a Unknown Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s After this certificate has performed 2 🗆 No 1 Tes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 X No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 🔼 Natural 5 Pending work? 2 No Accident Investigation by the 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide within 24 hours after
To the Funeral Direct
completed filled in b determined City or Town, State) Medical 29a. Certifier 🖊 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

> dhu 1, Day, Year) 11\_28

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ **THEODORE** HOPPE 0150 ROBERT 2010 07 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WORCESTER ATLANTIC GENERAL HOSPITAL BERLIN 8. Date of Birth (Month, Day, Year) 03/05/1940 Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 115-32-9028 1 X M 2 □ F Hours **NEW YORK** 70 **Director** Usual Residence of Deceden 28a-f shov 10a State 10b. County er than "natural", or Items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director VIRGINIA **ACCOMACK** ONANCOCK 1 Yes 2 X No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 23417 Funeral 22167 BAYSIDE ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 X Married ğ Maryland 21215-0036 1 ☐ Yes 2 X No If Yes, Give Year or Dates 1 Yes 2 X No Specify. WHITE Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) SCHOOL. CUSTODIAN permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ SYLVIA SWITZKOFSKI WILLIAM HOPPE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22167 BAYSIDE ROAD, ONANCOCK, VA JANE LEWIS HOPPE **SPOUSE** Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 07/29/10 RIVERHEAD. NEW YORK 4 Donation 5 Other (Specify) RIVERHEAD CEMETERY 21. Signature of Funeral Service Licenses 22. Name and Address of Facility WILLIAMS FUNERAL HOME, 94 MARKET ST., ONANCOCK, VA 23417 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Ph, sician/ Medical resulting in death) **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) physician the burial Physician/Medical attending p as IF FEMALE: Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the a 9 Unknown Part II. **Sing** significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Records, Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: A fer this certificate has completed filled in by the funeral director, page 2 s autopsy 1 Yes 2 No Vital 25. Was case referred to medica 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide (Month. Day, Year) 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Media Examiner: On the basic of examination and/or inventionable in the cause of examination and/or inventionable in the cause of examination and/or inventionable in the cause of examination and/or inventionable in the cause of examination and/or inventionable in the cause of examination and/or inventionable in the cause of examination and/or inventionable in the cause of examination and/or inventionable in the cause of examination and/or inventionable in the cause of examination and/or inventionable in the cause of examination and/or inventionable in the cause of examination and/or inventionable in the cause of examination and/or inventionable in the cause of examination and/or inventionable in the cause of examination and/or inventionable in the cause of examination and/or inventionable in the cause of examination and/or inventionable in the cause of examination and/or inventionable in the cause of examination and/or inventionable in the cause of examination and or inventionable in the cause of exam Medical 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ing Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature 29d. Date signed (Month, Day, Year,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JURP 10, 2010 ay Winfield Jacks 7:20 а м Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 3920 Hallowing Point Road Calvert Prince Frederick 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours October 24, 1946 MD Director 215-86-1679 63 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Calvert Prince Frederick 10e. Street and Numbe 10f. Zip Code "natural", or items 23a or edical Examiner must be π 10g. Citizen of What Country? Funeral USA 3920 Hallowing Point Road 20678 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗷 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes, Give Completed 3 Divorced 4 Divorced Black Year or Dates 27 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other than **Never Worked** None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Louis Jacks Charlotte Gray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 999, Prince Frederick, MD 20678 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Crea Axley - guardian 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Holland Cemetery 1 A Burial 2 Cremation 3 Removal from State July 16, 2010 | Huntingtown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sewell Funeral Home, P.A. 21. Signature of Funeral Service License 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final month Cancer. enysician/ as disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or se a nonesquence di) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Pregnant at time of death 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accider
3 Suicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the pasts of examination allows investigation, in this opening, seal to the state and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier

JRW 2

Registrar

DHMH 17 Rev 7/2009

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year

			- FOI	Department of Health and Mental Certificate of Death	Hygiene Reg. N2 0 1 0 25 1 7 0
			Decedent's Name (First, Middle, Last)		of Death 3. Time of Death
	Physici		Bonnic	Jenkins July	4 3 2010 1316 M
1	/Medio Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
			The Johns Hopkins Hospital	Baltimore City	
	Funeral		5. Social Security Number 6. Sex 1 M 2 X F	Months   Days   Hours   Min.   (Mon.	th, Day, Year) Country)
l.	Director		416-64-0026	Yrs. Jan.	12, 1949   Alabama
	land low		10a. State 10b. County 10c. City, Town	n or Location	10d. Inside City Limits
	Many a-f sh fied a	ctor	WV Jefferson Harper	rs Ferry	1 ☐ Yes 2√☐ No
	or 28	Director	10e. Street and Number	10f. Zip-Code	10g. Citizen of What Country?
	th wil	la [	4290 Chestnut Hill Rd.	25425	USA
	r dea	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, etc.	or No- 14. Race - American Indian, Black, White, etc.
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.  Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	by F	1 □ Never Married 2√ Married 1 □ Yes 2√ No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 🄀 No Specify:	Specify: White
8	hour tural' al Ex			Decedent's Usual Occupation	16b. Kind of Business/Industry
15	n "na ledic	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)	(Give kind of work done during most of working life. DO NOT use retired)	11
212	yiene.	E O	12	Housewife	Homemaker
פַ	othe othe	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, M	Middle, Maiden Surname)
/lar	uld b Venta Irked tic ev	2	Sidney Weeks	Rose Coll	<u> </u>
Maryland	2 sho and 1 is ma		19a. Informant's Name/Relationship (Type. Print) 19b	o. Mailing Address (Street and Number or Rural Route	Number, City or Town, State, Zip Code)
2	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Michael A. Jenkins - Husband 4	1290 Chestnut Hill Rd. Ha	rpers Ferry, WV 25425
Baltimore,	Pages 1 and 2 ment of Health a ant: If item 27 is ury or other tra		1 Burial 2V Cremation 3 Removal from State cemete	ry, crematory or other place)	
Ë	t. Pa tmen tant: ijury		4 □ Donation 5 □ Other (Specify) Hager  21. Signature of Funeral Service Licensee	rstown Crematory 8/3/10  22. Name and Address of Facility Facility	Hagerstown, MD
Bal	permit. Pages Department of Important: If i any injury or once.		D 1 1 D 1	Lackies	-Spencer & Norton Funeral
			23a. Part 1. Enter the disease, or con plications that caused the death. Do	Home Harpers Ferry, WV not enter the mode of dying, such as cardiac or respira	tory arrest. Approximate
	Discontinue		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	al disease	Interval Between Onset and Death
The state of the s	Physician /Medical		disease or condition resulting in death)  The disease or condition resulting in death)  Due to (or as a consequence of the disease or consequence of the disease or consequence of the disease or condition resulting in death)	c renal disase	
1	Examiner		- Pro Star	e neart diseas	e
	**	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	of);	
	outed d ransit	Examiner	Cause (Disease or injury that initiated events c.	infarction	
Ć,	an an arial-t		resulting in death) Last Due to (or as a consequence	of):	
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the buriat-transit	edical	d		
9	ng ph e as t		IF FEMALE:		
Box	leath certifi attending p d for use as	ian	23b. Was decedent pregnant in the past 12 months?  1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	a 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery  Month Day Year
	the a	Physician/M	1   Yes 2 No 4   Pregnant at time of death 9   Unknown 9   Unknown	3 Guier (specify)	
P.O.	hat the		Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I. 23e	. Did tobacco use contribute to the cause of death?
Records,	w requires that been signed I should be de	d by			1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
00	v requ	lete		24a.	Was an autopsy findings available prior to completion of cause of
Re	he lav e has age 2	Completed		1	autopsy performed? prior to completion of cause of death?  Yes 2 No 1 Yes 2 No
tal	sician: The lay certificate has irector, page 2	BeC	25. Was case referred to medical	26. Place of Death (Check	
of Vital	Attending Physician: 3r death. ector: After this certifice by the funeral director,	10 B	examiner? 1   Yes   2   No   Hospital: 1   Inpatient 2   ER/Ot	utpatient 3 DOA Other: 4 Nursing Home 5	Residence 6 Other (Specify)
	g Physer this		27. Manner of Death 28a. Date of Injury 28b. Natural 5 ☐ Pending (Month, Day Year) 28b.	Time of 28c. Injury at 28d. Des Injury Work?	cribe how injury occurred
Sio	eath. or: Aff	catic	2 Accident investigation	M 1 Tes 2 No	Control Number of Day Number
Division	n by t	Certification:	4 ☐ Homicide determined 28e. Place of injury - At home, fa building, etc. (Specify)		ttion (Street and Number or Rural Route Number, or Town, State)
	oital o		29a. Certifier 1 Certifying Physician: To the best of my knowledge	e death occurred at the time date and place and due	to the cause(s) and manner as stated.
	Hosp 24 ho Fune etely	Medical	(check only one) 2 Medical Examiner: On the basis of examination are and manner stated.	nd/or investigation, in my opinion, death occurred at the	e time, date and place, and due to the cause(s)
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has sompletely filled in by the funeral director, page 2	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	F > F 0		Zorg.	FH1503475	July 31, 2010
			30. Name and address of person who completed cause of death (Item 23a)		
9	4-6		James Harris Jr. M.D.	600 North	Wolfe St, Baltimore, MD, 21287
	Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signature	1	R
	Registi	ar	AUG 0 2 2010	Sark	

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Mandrin Chesapeake Hospice House Anne Arundel Harwood g. Birthplace (State or Foreign Country) Kansas Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Funeral 1 🗆 M 2 💆 Months Days Hours Min (Month, Day, Year) 510-30-1730 77 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 2566 Hidden Cove Rd. 21401 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: White If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Arnold Call Gladys Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2566 Hidden Cove Rd., James S. Keeny/ Husband Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenwood Cemetery 7/27/10 Sedan, Kansas 21. Signatur of Juner Service Licenses 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter underlying Cause (Disease or linjury Examine Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed and that initiated events resulting in death) Last use as the burial-trar Due to (or as a consequence of): signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant g Unknown Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s autopsy performe 25. Was case referred to medical examiner? 26. Place of Death (Check only one) æ Hospital: Other: 2 100 1 Yes Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) within 2 To the I 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 16, 2010 Joyce King 10:33 A Medical 4a. Facility Name (if not institution, give street and number) <sup>4c. County of Death</sup> Prince George's **Examiner** 4b. City, Town, or Location of Death Temple Hills 4508 Hargrove Road 7. Age (In yrs. last birthday) 82 Yrs. If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Min. 556 58 0453 1 □ M 2XX F Months Hours Country) China Director Aug Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Examiner must be notified Temple Hills Prince George 's Maryland 1 Yes 2 No 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 20748 4508 Hargrove Road United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, 6 \$ 1 Never Married 2 Married 72 hours after Maryland 21215-0036 1 Yes 21 No Specify Chinese Specify: "natural" Completed 3 X Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Math Professor Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4508 Hargrove Road, Temple Hills, MD 20748 David Kwan (son) Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Clinton, Maryland Resurrection Cemetery July 24, 2010 4 Donation 5 Other (Specify) 21. Sign tur of Funeral vervice Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 old Alexandria Ferry Road, Clinton, MD 20735 ours Tan 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ Alzheimers Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Dust for (unas a consequence of) If a y leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year ed by the a detached f 9 Unknown s been signed to should be deta Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2: autopsy performed 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home} \) 1 Nursing Home 5 \( \text{XX} \) Residence 6 \( \text{Other} \) Other (Specify) 2 11 No 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at (Month, Day, Year) 1 Natural 5  $\square$  Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 1 🗌 Yes 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Effectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) vage O. VellT July 19, 2010 D23743 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martin Weltz, M.D. 7525 Greenway Center Drive, #205, Greenbelt, MD 20770 31. Date filed (Month, Day Year) 💋. Registrar's Signature State park

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 25173 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Robert Louis Kiiffner Year 10:13 AM 2010 In l v Medical 4c. County of Death Allegany 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cumberland 825 Columbia Avenue 5. Social Security Number 9. Birthplace (State or Foreign . Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Year) 10/18/1919 1 X M 2 A F Months Days Hours 90 213-16-9693 Director Maryland Usual Residence of Decedent or 28a-f show 10a. State at 10c. City, Town or Location the Maryland 10d. Inside City Limits Director Examiner must be notified MD Allegany Cumberland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 23a 825 Columbia Avenue with or items within 72 hours after death 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. Š 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give "natural", Specify. 3 Widowed 4 Divorced Completed Year or Dates White traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Pipefitter Railroad permit. Page 1 and 2 should be filed win Department of Health and Mental Hygie Important: If item 27 is marked other any Injury or other traumatic event, til once, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kiiffner ပ Frederick Fredericka Trauterman John 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy R. Phillips / Daughter 807 Edgewood Drive, Cumberland, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 💢 Burial 2 🗆 Cremation 3 🗆 Removal from State Greenmount Cemetery ! 07/26/2010 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, 21. Sign tune of Funeral Service Lin 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Metastatic Physician Mo Medical resulting in death) Examiner COPD Sequentially list conditions, it cause. Enter Underlying Examiner Due to or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the bunal-transit Cause (Disease or linjury as fery oronary that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Pregnant at time of death Month Year Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: Certificate: To 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 K Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 28f. Location (Street and Number or Rural Route Number City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0059987 July 23, 2010 none M frustowhen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Christopher Vagnoni. M.D., 925 Seton Drive, Cumberland, MD 21502

State Registrar 31. Date filed (M

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 39 Warren Lee Lewis, Sr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Western MD Regional Medical Center Cumberland Allegany 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Months Hours Min (Month, Day, Year) 07/10/1948 Country) Maryland 218-48-7709 62 Director Usual Residence of Decedent show 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified MD Allegany Cumberland 1 🛛 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 468 Baltimore Avenue USA 21502 items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Page 1 and 2 should be filed within 72 hours after deat ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or iter ury or other traumatic event, the Medical Examiner. 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 N Married Yes f Yes, Give 2 □ No 1967-Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed 1976 White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Dispatcher Transportation 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Spiker Harry Grant Lewis, Sr. Emma Mabel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11609 Valley Road, Cumberland, MD 21502 Robert Easton / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 X Cremation 3 Removal from State Cumberland Crematory 07/26/2010 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Son ture of Funeral Service 404 Decatur Street, Cumberland, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 3 days Physician/ Jups s disease or condition Medical resulting in death) Due to or as a consequence of): Examiner 1 year renal disease End Stage Sequentially list conditions, Due to (or as a conse Ince of): if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Exami or Attending Physician; The law requires that the death certificate be executed and burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician hed for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 2 No detached 9 Unknown 9 Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Metastatic small cell lung concer 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? this certificate 1 Yes 2 No Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) Certificate: To 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Ph.
within 24 hours after death.
To the Funeral Director: After th completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0059987 123 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Christopher

26 2010

31. Date filed (Month, Day, Year)

parks

Vagnoni, M.D.,

32. Registrar's Signature

925 Seton Drive, Cumberland, MD

21502

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٥,	Examin		4a. Facility Name (if not institution, gi	. 1 4 - 1 2		4b. City, Town, o	r Location of Death		4c. County of Dea	th
5			Furestville He		4	Fore				œuze
James	Funeral			. 📆 🗆 =	yrs. last birtho	day) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bii	rthplace (State or Foreign buntry)
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	und show at	ē	10a. State 10b. County	10	Oc. City, Town	or Location				10d. Inside City Limits
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we hear	should and Me is mar raumati		19a. Informant's Name/Relationship		19h	Mailing Address (Street	and Number or Rura	al Route Number.	City or Town, State, Z	ip Code)
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4	Physician/	3	Immediate Cause (Final	one cause on each line.	1.	ha. I	Ell a			Interval Between Onset and Death
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<b>5</b>	Phys r this eral di	e: To	27. Manner of Death	28a. Date of injury	28b. Tir	ne of 28c. Injur			ence 6 Other (Spe	SITY)
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	Not To t		29b. Signature and title of certifier			29c. Licens			29d. Date signed (Mon	
			▶ ////wall				51520		07-27-	2010
1	206		30. Name and address of person wh	o completed cause of death	h (Item 23a) (Ty	vpe, Print) ロロでほとべ ケイ	3. SE 4	VASHING!	TON DC	200.32
	IN		81. Date filed (Month, Day, Year)	32 Palietror's					,	
1	Stat Registra	e ar	JUL 28	2010		back				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For state
Registra MEND#260erMD, 8/3/10, EMW, McCo Certificate of Death Decedent's Name (First, Middle, Last, 2. Date of Death Month Physician/ 7:00 am Elaine Anne Mitchell 2010 16 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bethesda Montgomery Brighton Gardens of Tuckerman Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** March 10, 1928 1 🗆 M 2 🗶 Ohio 82 287-24-6605 Director Usual Residence of Decedent Baltimore, Maryland 21215-0036

Penalt. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If fiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No Bethesda Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20817 u.S.A. 8216 Burning Tree Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Yes 2 X No Yes, Give Itimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: 3 X Widowed 4 Divorced White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Weight Loss Office Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ernest Swanson Edna Gray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8216 Burning Tree Road. Bethesda. Maryland 20817 Kevin Mitchell - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Ft 07/29/2010 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crem. . Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute & Cremation Ctr. Rockville Pike. Rockville, Maryland 20852 23a. Part 1. Fr. er the dis ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, r heart allu a. List only one cause on each line. Approximate Interval Between Onset and Death Immediate use (Final disease or condition resulting in death) Physician/ Lung Adenocarcinoma Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a nonsequence of: or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and the burial-trar Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Day 5 Other (specify) Month Year cate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? Yes 2 X No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical the funeral director. 26. Place of Death (Check only one) Be examiner? Other: 4 X Nursing Home 5 X Residence 6 - Other (Specify) 2 🔁 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A? Investigation 」 Accident ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29c. License numbe 29d. Date signed (Month, Day, Year) 10 July 21. 2010 H45839 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Gary Raffel, MD 5413 West Cedar Lane #203-C. Bethesda. Maryland 31. Date filed (Month, Day, Year)

JUL 28 2010 2. Registrar's Signature State Registrar

0-05830	Please Type or Print in Black Indelible Ink. Ensure All Copies	Are Legible.			
Serman Molina Moreno	State of Maryland / Department of Health and Mental Hyg	jiene 🤈	nin	2517	1
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	Name (First Middle Loot)	Date of Death		3. Time of Death	_

		I- For State Registrar	to or mary and / D	Certifica	te of Death		Re	g. No.	23111
Physicia Medical Exami	ın/	Decedent's Name (First, Middle German	Molina	More	eno		2. Date of Death Month August 4, 2	Day Vear	3. Time of Death 1025 hrs
		4a. Facility Name (if not institution 9644 Ft. Meade Road	give street and number)		4b. City, Town, o Laurel	r Location of Death		4c. County of Death Prince George	
Funeral Director			S. Sex 7. Age (In	yrs. last birtho	day) If Under 1 Ye Months Da			h(MM/DD/YYYY) 9. Bir 1969 Foreig Co	thplace (State or gn MACXICO
Maryland 28a-f show any d. at once.		Usual Residence of Decedent  10a. State  MD  10b. County Prince	e George's	City, Town or Laur					10d. Inside City Limits 1 X Yes 2 No
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MD 21  Id 2 should  ulth and Me m 27 is mar	٥	19a. Informant's Name/Relationsh Martha Gomez	Nucamendi/	91	100 Phili	p Court	Laure	ber, City or Town, State  1, Md 2070  20c. Location - City or	8
Baltimore, MC permit. Pages 1 and 2 s Department of Health an Important: If item 27 injury or other trauma		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other Section  21. Sig above f Funeral Service	Removal from State	Panteo		San- 8/ RIWALD		Villacor Mexico RAL SERVI	zo,Chiapas
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Division of Vital Records, ral or Attending Physician: The law requirers after death.  **I Director: After this certificate has been silted in by the funeral director, page 2 should be	Completed by						24a. Was a autop: perfor	sy prior to med? death?	utopsy findings available completion of cause of
fital F sician: is certifi lirector,	BB	25. Was case referred to medical examiner?	Hospital: 1 Inpatient	2 ER/Out	26.Place	Other Nursin		Residence 6 🗸 Othe	er: Scene
on of Vital   ending Physician: ath. rr: After this certifi he funeral director,	tion: To	1 ✓ Yes 2 No  27. Manner of Death  1 🗶 Natural 5 Pendi		28b. Ti		ury at Work? Yes 2 No	28d. Describe h	now injury occurred	
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	Certification:	3 Suicide 6 Could determ	not be	- At home, fan	m, street, factory, office	building, etc.	28f. Location (S or Town, S		ural Route Number, City
Divis  To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical (	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my knowniner: On the basis of examination and manner stated.	owledge, deat tion and/or in	h occurred at the time, vestigation, in my opinio	date and place, and on, death occurred a	due to the caus at the time, date	e(s) and manner as sta and place, and due to tl	ted. ne cause(s)
3	Me	29b. Signature and title of certifier				se number		29d. Date signed (Mo	onth, Day, Year)
		30. Name and address of person Ling Li, MD Assistar			Street, Baltimore	, MD 21201			
S	tate	31. Date filed (Month, Day, Year)	32 Registrar's S	ignature	arke				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician Miill William Marcus Duli 23,2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury Rehabilitation & Mursing Ctr Wicomico Salisburu 9. Birthplace (State or Foreign Country) South Carolina 5. Social Securify Number If Under 1 Year | If Under 24 Hrs Sex 10 M 20 F 7. Age (In yrs. last birthday) **Funeral** Min. Months Davs Hours 03/02/1926 84 247-36-8556 Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show r 28a-f sh 1 X Yes 2 ☐ No Director Wicomico Hebron Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 1 may injury or other traumatic event, the Medical Examination at being the 1000e. 21830 USA 26299 Rewastico Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify white <u>م</u> Year or Dates: Navy 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Welder welding 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Walter Mull Sarah Magill ပ္ 19a. Informant's Name/Relationship (Type. Print) Edna E. Young/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7732 Quantico Rd., Hebron, MD 21830 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20h Place of Disposition (Name of Date Springhill Melliory 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 7/27/2010 Hebron, MD 4 ☐ Donation 5 ☐ Other (Specify) Gardens Egneral Syrvice Licensee Name and Address of Facility
Holloway Funeral Home Professional Association # 501 Snow Hill Rd., Salisbury, MD 21804 Kompson CFSP 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) week /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (ur as a consequence of): ils certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐Yes 2 ☐ No 24a. Was an autopsy 2 **(2)** No 1 ☐ Yes Hospital or Attending Physician: 24 hours after death.
 Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Medical npletely To the within 2.

Division of Vital Records, P.O. Box 68760,

Maryland 21215-0036

State

29a. Certifier

(Check only one)

31. Date filed (Month

29b. Signature and title of certifier

30. Name and address of person who comed ted cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Civic Ave. Salisbury, MD 21804

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July **Physician** 2010 24, 11:30 AM **PETERSON** MCLANE ELLEN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Dorchester Cambridge Mallard Bay Nursing Home | If Under 1 Year | If Under 24 Hrs. | 8, Date of Birth (Month, Day, Under 18) | Min. | Jan. 18, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 93 1 □ M 2 🖾 F 217-30-7865 Jan. Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show Yes 2 □ No permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f st any hjury or other traumatic event, It. Involved. Director Crisfield Maryland Somerset 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 21817 17 E. Main Street USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 \( \subseteq Yes \) 2 \( \subseteq No \) 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White ð 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Beautician Cosmetology 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Axel Peterson ပ Esther Clausen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne Peterson (Nephew/PR) 5411 Bonnie Brook Road - Cambridge, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Sunnyridge Memorial Park 07/27/2010 4 ☐ Donation 5 ☐ Other (Specify) Crisfield, MD 22. Name and Address of Facility Bradshaw & Sons Funeral Home Robert H. Bradshaw Jr. 306 W. Main St. - Crisfield, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1ewal O days /Medical Due to (or as a consequence of): Examiner Malignancy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans advanced Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à icate has been si, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes of Vital this certific al director, 25. Was case referred to medical examiner?
1 ☐ Yes No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi 27. Manner of Ceath 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at/ Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a, Certifier 1 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and tife of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 21<sup>Day</sup> Physician/ Grace Jacqueline Nickas July 2010 2:00  $P^{M}$ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Crofton Care & Rehabilitation Center Crofton 8. Date of Birth
(Month, Day Ye 9. Birthplace (State or Foreign Country) Ohio 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** Days <sup>Year)</sup>1926 1 □ M 2 🔀 F Months Hours 83 Director 234-36-0482 Usual Residence of Decedent show. or 28a-f shov notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2X No Lothian Anne Arundel MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or must be n Funeral 20711 USA 278 Janet Ct. "natural", or items edical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? þ 1 Never Married 2X Married ☐ Yes Maryland 21215-0036 Specify: White 1 Yes 2X No Specify: If Yes, Give Year or Dates. Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "n:
any injury or other traumatic event, the Medic Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 8 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Grace Stevenson Owen Handley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chris J. Nickas, Jr. / Spouse 278 Janet Ct., Lothian, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State 7/23/2010 Metro Crematory Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 23a. Pdd 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Deal Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and that initiated events (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as t the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? for Month Dav Year Pregnant at time of death 9 Unknown s been signed by the should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed? certificate Yes 2 No Yes 2 No 25. Was case referred to medica examiner? funeral director, 26. Place of Death (Check only one) Be Hospital 2 Z No Other: 1 U Yes Nursing Home 5 Residence 6 Other (Specify) မြ 1 Inpatient 2 ER/Outpatient 3 DOA this ( 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury a 28d. Describe how injury occurred Certificate: injury work Natural 5 Pending nours after death.

neral Director: Af
d filled in by the fu 1 Ves 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined within 24 hours a To the Funeral I completed filled Medical 1 Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) CI 22 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

Rakesh Arora, M.D.,

31. Date filed (Month, Day, Year)

14300 Gallant Fox Lane,

Bowie, MD

20715

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-1 show any injury or other traumatic event; it a Medical Examination into the traumatic event; it a Medical Examination into the traumatic at a pince. Baltimore, Maryland 21215-0036

Physician

Division of Vital Records, P.O. Box 68760,

/Medic	cal	DOMETVILLE NIO	1011001	, 01.			-				July		2010		11:30 b	
Examin	ner	4a. Facility Name (If not institution, give street and number)						4b. City, Town, or Location of Death 4c. County of Death								
		18125 Lappans	Road				Fai:	rplay	У				Washington			
Funeral		5. Social Security Number	6. Sex	7. A	ge (In yrs. la	st birthday,			If Under		8. Date of Bi (Month, D	rth	9. Birthplace (State or Foreign			
Director		215-26-9593	1 <b>₹</b> M	2□ F	83	Yrs.	Months	Days	Hours	Min.			926		vland	
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Mer Mer arke	ျ	Somerville Nicholson, Sr.  Lovise Edwards  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)														
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alth a	ш	Susan A. Nicho	lson -	<ul><li>wife</li></ul>		1812	5 Lap	pans	Road	l, Fa	irplay	, Ma	aryla	nd 2	1733	
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it a Medical Examination in sufficed at once.		21. Signature of Funeral Service	Licensee		•		2. Name an				MINNIC	H FU	NERA	L HO	ME	
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	(Check only 2☐ Medical one)		On the basis and manner s		on and/or i	nvestigation	, in my of	pinion, de	ath occur	rred at the time	, date a	and place,	and due	to the cause(s)	
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Registr	dľ		~ ~~~	A Com		full the										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 9:37p M Phung July 22, 2010 Xuan Nguyen /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Prince George's Hospital Cheverly Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1**X**0 M 2□ F 70 April 25, 1940 Vietnam Director 218-37-0455 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Bladensburg Director Maryland Prince George's 10g. Citizen of What Country? 10e. Street and Number 20710 U.S.A. 5999 Emerson Street, Apt. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify þ Asian 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) mit. Pages 1 and 2 should be filed within sartment of Health and Mental Hygiene. oortant: If item 27 is marked other than Injury or other traumatic event, the M Apartment Repairs Maintenance Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked o any Injury or other traumest-Cuc Thi Phan Van Nauyen ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6508 Perry Street, Hyattsville, Maryland 20784 Phuong K. Nguyen - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cem. 07/27/2010 | Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. NO[24/11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ttemorrhage -non traumatic ntracrania **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed as the burial-transit Due to (or as a consequence of) DivÍsion or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Dav 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 21 No 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending P within 24 hours after death.

To the Funeral Director: After it 1 Natural 2 Accident (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a), (Type, Print)

Matin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar		State o	of Ma	aryland	-	irtment tificate			nd Me	ental Hy	giene Reg. N	20	0	25183
Physi	cian		1. Decedent's Nam		*								2. Date of Dea	ath	ay	Year	3. Time of Death
Me	dica	al -		Byron l		aha d			4. O'. T	-1. 1.1		Death	July 2	25 <u>,                                    </u>	2010	)	2:00 A M
Exar	nine	r	4a. Facility Name (if Anne Aru	-		-	-			,	Location of Capolis				4c. County of Death  Anne Arundel		
Funer	_		5. Social Security N	umber 6	Sex		(In yrs. las	st birthday)	If Under 1		If Under 24		8. Date of Birt	th vYear)		9. Birth	place (State or Foreign
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death i items	١,	Funeral	11. Marital Status		12. Was Dece Armed Fo	edent Ev	ver in U.S.	I.S. 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu			n? (Speci	? (Specify Yes or No-			14. Race - American Indian, Black, White, etc.		
after after sall, or xamir	:	g p	1 ☐ Never Marr 3 ॉ¥Widowed	ied 2 Marrie	1 Yes If Yes, Giv Year or Da	2 🗆 ۱		1	Yes 2				,,		Specify:		
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Mar 2 shoul th and 27 is m trauma													Route Numbe			tate, Zip	Code)
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Page 1			1 🔁 Burial 2 4 🗌 Donation	ce	emetery, crem	Disposition (Name of crematory or other place)  Pate 20c. Location - City or Town, State crematory or other place)  Pate 20c. Location - City or Town, State crematory or other place)  Crownsville, MD											
baltimore, permit. Page 1 and 3 Department of Heali Important: If item 2 any injury or other	once	1	21. Signature of Fu	heral Service Lic	ensee			22.		Address	of Facility	Bea	all Fur	era	1 Hor	ne	
		+	23a. Part 1. Enter a shock, or hea	ne disease, or co	mplications that	caused	the death								ב עוא	2071	Approximate
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uted nd ransit		Examiner	Cause (Disease or that initiated event	rlying linjury	C			ν									
foucate be executed physician and the burial-transit			resulting in death)	Last	Due to	(or as a	conseque	ence of):									
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he death of the atter		by Physician/M	1  Yes 2 Unknown	□ No	4 🗀 Preg 9 🗀 Unki		time of de	eath 5∟	Other (spec	:ify)					Moi	11111	Day Year
that the			Part II. Other signit	ficant conditions	contributing to d	leath bu	ut not resu	ılting in the uı	nderlying cau	use give	en in Part I.						the cause of death?
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F VIII Physic this ce		ا		□ No	Hospital: 1 28a. Date			ER/Outpatien			4 L Nurs	$\overline{}$	ne 5 Resid				y)
on or nding Pl ath. : After the e funeral		cate	1 Natural 2 Accident	5 Pending Investiga	(Mon	th, Day,		injury	M	. Injury work? 1 🗆 Y	at ∕es 2□N		3d. Describe h	iow inju	iry occurre	ed	
DIVISION OF VITAL RECORDS, F.O. BOX 09 (The Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending it completed filled in by the funeral director, page 2 should be detached for use as		Certificate:	3 Suicide 4 Homicide	6 Could no determin	t be 28e. Place		ry - At hor . (Specify)	me, farm, stre	et, factory, o	ffice		21	8f. Location (S City or Tow			er or Rura	al Route Number,
Spital hours a meral C		- F	29a. Certifier 1	Certifying P	hysician: To the b	est of r	ny knowle	edge, death o	ccured at the	e time,	date and pla	ace, and	due to the ca	use(s) a	ind manne	er as state	ed.
the Ho thin 24 the Fu mplete	2		only one) 3	Certifying N	miner: On the bas urse Practioner:				eath occurred	d at the	time, date ar			e cause	(s) and ma	nner as s	
გ.≱ გ. მ			29b. Signature and	Cartiller	A	~	~	in		-0	number 3 3	00		29d. D.	ate signed	(Month, 	Day, Year)
			30. Name and addr	ess of person wh	o completed caus	se of de	eath (Item	23a) (Type, P		<u> </u>							-
HID	† \ State		Cuff 31. Date filed (Mont			1 9	r's Signatu	150°57	goto	Le	1 54	C 36	O An	na	Polis	, u	1121418
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 24, 2010 Jesse A. Poole, Jr. 11:05 PM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Prince George's Southern Maryland Hospital Clinton If Under 1 Year Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Days Min 1 XM 2 1 Washington, Yrs. 578-20-3480 **Director** 87 Usual Residence of Decedent Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No MD Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14997 Health Center Drive 20716 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates.1944-45 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc ģ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Completed White 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Machine Tool Specialist U.S. Navy Dept. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Jesse A. Poole, Sr. Grace Suddarth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 Health Center Dr. #235, Bowie, MD Catherine G. Poole / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛮 Burial 2 🗌 Cremation 3 🗔 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/30/2010 Fort Lincoln Cem. Brentwood, MD 21. Signature of Funeral Service 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., 23a. 1 1. Enter the Dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart follure. List only one cause on each line. Immediate Cause I Inal disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence oil Exami death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): anding physician a use as the burial-1 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 238. Did tobacco use contribute to the cause of death? ģ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 2 🗌 No 1 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) 1 🗌 Yes 2 No ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at Matural 5 Pending within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title

Registrar
DHMH 17 Rev 7/2009

State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

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son who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Verna McAllister July 2010 7:20A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6225 Cool Springs Farm La Plata Charles 9. Birthplace (State or Foreign Country) New York 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) yember 27,1933 Funeral Age (In yrs. last birthday) 1 □ M 2 🔀 F Hours Director 214-32-7968 76 November Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No MD Charles La Plata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6225 Cool Springs Farm 20646 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No ò 1 Never Married 2 Married 1 Yes If Yes, Give Saltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: White Specify. 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Clifford John McAllister Marion Louise McAllister 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20677 David Posey/Son 8500 Chapel Point Road, Port Tobacco 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State St. Ignatius Cemetery 7/31/2010 4 ☐ Donation 5 ☐ Other (Specify) Port Tobacco, Maryland M0094521. Signa are of Funeral Service Licensee <sup>22</sup>AREHART ECHOLS FUNERAL HOME, P.A. Mary's Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Pnysician/ Newsoundscring year disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, from clate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to for as a consequence of Exam attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Live Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No 1 Live Birth
4 Pregnant
9 Unknown Month Day Year Pregnant at time of death funeral director, page 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy death? 1 🗆 Yes 2 No ☐ Yes 2 by No 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 X No Hospital Other: 1 Tyes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 TResidence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending 24 hours after death. Funeral Director: Af Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On he basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Pra tioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0033426

State

Larry

DHMH 17 Rev 7/2009

Registrar

P.O. Box 2665, La Plata, MD

Registrar's Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jenkins, M.D.

7-28-10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 4:30 A M Medical a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Park Mont AKUMA gomery 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 9, Birthplace (State or Foreign Birthpic Country) **Funeral** 1 🗆 M 2 🕱 F Months Days Hours Min. 1939 Director 213-38-0116 MAIZT Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 X Yes 2 No Maryland 10g. Citizen of What Country? 10e. Street and Number Funeral 15608 Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Black, White, etc. þ 1 X Never Married 2 Married 2 X No within 72 hours after Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: "natural", 3 Divorced Completed Block the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Courselon 7)c General 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mickeral 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20774 Michele MI 608 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Marzyland 29-10 4 ☐ Donation 5 ☐ Other (Specify) Wolder Signature of Funeral Service Lighnsee Name and Address of Facility MA 20608 M01589 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 4Sis Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine If any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): -transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or it that initiated events and Due to (or as a consequence of): resulting in death) Last physician a s the burial-1 Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 month 1 Yes 2 No Month Day Year Pregnant at time of death Unknown signed by the a 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 🗌 Yes No 3 Probably 4 Unknown Completed 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate ha perforn 2 No 1 Yes 25. Was case referred to medica within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 2 **X**No မ 🗶 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27-Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 2 🗌 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Daţe signed (Month, Day, Year) 1006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YLOMA 7600 CARROL ASHISM TOU 31. Date filed (Month, Day, Year)
JUL 28 2010 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 24, 2010 Physician/ Walter Alton Raley, Sr. 6:10 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Southern Maryland Hospital Clinton If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Security Number 218 52 8367 8. Date of Birth 7. Age (In vrs. last birthday) Funeral Hours Sept 13. 1 XM 2 - F 62 Baltimore, MD Director Usual Residence of Decedent show 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10c. City, Town or Location 72 hours after death with the Maryland Director 1 ☐ Yes 2 🋣 No Upper Marlboro Prince George Maryland 10e. Street and Number 10g. Citizen of What Country? Funeral United States 20772 6513 Rosemont Street 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 X Married þ 1 Yes 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates and Mental Hygiene.

Is marked other than "natur aumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 i Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ni any injury or other traumatic event, the Montal Once. (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Welder Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Conklin Raley Nellie Luet Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6513 Rosemont Street, Upper Marlboro, MD 20772 Linda A. Raley (Wife) 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of 1 ☐ Burial 2 XX remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Clinton, Maryland Lee Crematory July 29, 2010 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 21. Sig Hure of Funeral Service Licensee Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final INFARCTION Onset and Death MYOCARDIAL Pitysician/ ACUTE disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** DISEASE CORONARY Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No hed by the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MELLITUS DIABETES 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director. 25. Was case referred to predical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: 2 ER/Outpatient 3 DOA 27. Manner of 28a. Date of injury 28b. Time of 28c. Injury at (Month, Day, Year) tural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in tily opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tide D0064986 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State JUL 28 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month © 7 Physician/ George Julian Rotariu 8:11 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicamica Salis burn Coastal Hospice at the 8. Date of Birth Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, Funeral 1 MM 2 □ F Min. Months Days Hours 08/24/1917 326-24-7336 92 California Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location and 2 should be filed within 72 hours after death with the Maryland items 23a or 28a-f sho ner must be notified at Director 1 Yes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 916 Winding Way 21804 IISA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status the Medical Examiner Armed Forces?
1 ☐ Yes 2 🗷 No Black, White, etc. ò 1 Never Married 2 X Married ģ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: and Mental Hygiene. is marked other than "natural", If Yes Give white 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 scientist Dept. of Energy Be ary or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Julian Rotariu Anna Cornut 19a. Informant's Name/Relationship (Type, Print)
Janet M. Rotariu/spouse 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 916 Winding Way, Salisbury, MD 21804 ment of Health a filmore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State wicemetery, crematory or other place Wicomico Memorial PARK 1 X Burial 2 Cremation 3 Removal from State 7/26/2010 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD Depart Impor any in 22. Nama and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 CFSP Homenort 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition CARDIOM YOPATHY Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time of death IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an perform within 24 hours after death.

To the Funeral Director: After this certificate he completed filled in by the funeral director, page 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Pertitying Nurse Practioner: To the best of my knowled je, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) asp 21802 PU BUP

DHMH 17 Rev 7/2009

State Registrar Registrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend I tem 7 per FH 6907 9/8/10 dk
State of Maryland / Department of Health and Mental Hygiene [ ] | [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Daniel Graciano Rosas 78:17 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death . **Examiner** SAVISBUIL NIONALO REGIONAL PENINSULA If Under 24 Hrs. Funeral Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 **X** M 2 □ F Min. (Month, Day, Yes) / 23 / 2010 nla Hours 5 Mary land Director Usual Residence of Decedent 28a-f shov ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No Ocean City Maryland Worcester 10f. Zip Code 10g. Citizen of What Country? Funeral 21842 USA 105 Caroline St., Apt. 5 death v 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examin any. <u>م</u> 1 K Never Married 2 Married Baltimore, Maryland 21215-0036 1 →Yes 2 No Specify: Mexican hispanic If Yes, Give 3 🗌 Widowed 4 🗆 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) nla nla Be 18. Mother's Name (First, Middle, Maiden Surname)
Leslie Rosas 17. Father's Name (First, Middle, Last, ည Arturo Graciano 19a. Informant's Name/Relationship (Type, Print)
Arturo Graciano/father 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 105 Caroline St., Apt. 5, Ocean City, MD 21842 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/27/2010 Salisbury, MD Salisbury Crematory 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 21. Signature of Furreral Service Licen 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Severe melabolic acidosis disease or condition Medical resulting in death) Due to (or as a consequence of): 5 hus Examiner no Tension Severe Sequentially list conditions, if any, leading to incrediate cause. Enter Underlying Examiner -transit the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events 23 w celler Extreme and Due to (or as a consequence of): resulting in death) Last burialphysician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death signed by the a d be detached f Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 H Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy funeral director, page certificate | 1 Yes 2 X No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No ျ 1 🗷 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury work?
1 Yes 2 No 5 Pending s after death. Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined 24 hours a Funeral I Medical 29a. Certifier 🖪 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the 29b. Signature and title of certifier . License number 29d. Date signed (Month, Day, Year) 07 23 2010 51310-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MISBAH. Carroll St. SAlisbury, Md. 21801 LURESHI' 100 E 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 28

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Juanita Elizabeth Raab 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death REGIONAL WICOMIO TENINSULA 54L/Sb4/C Age (In yrs. last birthday)
77 Yrs. Social Security Numbe If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖺 F Months Days Hours Min. 12/01/1932 Maryland Director 212-30-0007 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location notified at 10d. Inside City Limits Director 1 Yes 2 No Maryland Worcester Pocomoke City 10e, Street and Numbe 10f. Zip Code I Hygiene. I other than "natural", or items 23a or went, the Medical Examiner must be I 10g. Citizen of What Country? Funeral 106 Payne Ave. 21851 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married 2 X No Yes Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: Specify: white Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 2 should be filed with h and Mental Hygien 7 is marked other th 11 food production Perdue Farms, Inc. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ unknown unknown traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Bruce Raab/son 106 Payne Ave., Pocomoke City, MD 21851 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 🖺 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 7/26/2010 Salisbury, MD 21. Signature of Funeral Service Lig <sup>22</sup>Name and Address of Acceptal Home Professional Association Kellesc 107 Linden Ave., Pocomoke City, MD 21851 23a. Part 1. Enter the disease, or comple ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only o Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions rany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ng physician and as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical e attending p 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performe certificate Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tes ဂ္ ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 - Pending within 24 hours after death.

To the Funeral Director: After completed filled in by the fur 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Registrar DHMH 17 Rev 7/2009

State

To the I within 2

29b. Signature and title of certifier

Kamesh

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

49DINAL

Baltimore.

68760

Box

P.O.

Records,

of Vital

Division

32. Registrar's Signature

D54807

CAMOIL

29d. Date signed (Month, Day, Year)

7-26-2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 19, 2010 av 12:38 p M James L. Sherrell Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Marys Lexington Park 21354 Windsor Drive 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** 1 🗷 M 2 🗆 F Months Hours Min. December 21, 1938 Director 231-44-6275 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 No Lexington Park MD Saint Marys 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 20653 21354 Windsor Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces

1 Yes 2

If Yes, Give
Year or Dates. Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married 2 - No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 KNo Specify: Specify "natural", 3 Widowed 4 Divorced Black Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) th and Mental Hygiene. 27 is marked other than ' traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) **Power Plant** Control Operator filed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be file trment of Health and Mental I rtant: If item 27 is marked o မ Gladys L. Knight James Sherrell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22478 Meath Road, Great Mills, MD 20634 Marie A. Berry - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1
Department of
Important: If it
any injury or o 1 ABurial 2 Cremation 3 Removal from State Cheltenham Veterans Cem. July 29, 2010 | Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) Sewell Funeral Home, P.A. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gladen 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between set and Death Immediate Cause (Final Gnysician. disease or condition resulting in death) Medical Due to (or as I **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burla Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death the detached 9 Unknown P.O. þ 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be dei þ Records, 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 2 No 1 Yes Yes thin 24 hours after death.

the Funeral Director: After this certific
mpleted filled in by the funeral director, 26. Place of Peath (Check a l Division of Vital æ ase re extrininer? Other: 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 1 Natural Accident work?

1 Yes 5 Pending 2 🗌 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying National To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the I Certifying Natse 29b. Signature and title of ce

DHMH 17 Rev 7/2009

State Registrar

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30. Name and address

an

31. Date filed (Month, Day

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th (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Dhysioic	m/	1. Decedent's Name									2. Date of De	eath			3. Time o	of Death
	Physicia Medic		Louise A						_			July	23	20]	L O	8:10	РМ
	Examir	er	4a. Facility Name (if n			imber)			4b. City, Town, o		of Death			c. County of			
10-8-1 <sup>2*</sup>	Funeral		Spa Creek 5. Social Security Nur		. Sex	7. Age	(In yrs. las	t birthdav)	Annapol:		r 24 Hrs.	8. Date of Bir		Anne A		del place (State o	or Foreign
	Director		252-10-033 Usual Residence of D	35	1 □ M 2 💢 F	,	93	Yrs.	Months Days	Months Days Hours Min. 7/14/					1916 Country) GA		
	and show 1 at	ō		10b. County	- 10	T	10c. City,	Town or Loc	ation						1	0d. Inside C	ity Limits
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	h the la or i	a D	10e. Street and Numb			•			10f. Zip Code				10g. C	itizen of Wh		try?	
	th wit ms 23 must	<b>Funeral Director</b>	87 Shipwri	ight St				21401 n.U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or N						USA			
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ğ	11. Marital Status 1 ☐ Never Married 3 🛣 Widowed 4		12. Was Dec Armed F 1 Yes If Yes, G Year or I	orces? 2X11 ive		lf lf	/as Decedent of H Yes, specify Cuba ☐ Yes 2 XNo	n, Mexica	n, Puerto f		14. Race - Amer Black, White Specify: Wh			etc.	
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ary	should and M is ma		19a. Informant's Name/Relationship ( <i>Type, Print</i> )  19b. Mailing Address ( <i>Street and Number or Rural Route Number, City or Town, Stat</i>										e, Zip C	ode)			
Σ.	nd 2 stealth m 27		Suzanne Weissinger (daughter) 87 Shipwright St. Annapolis, MD 2140								21401						
lore	ge 1a nt of H : If ite or oth	l í	20a. Method of Dispos 1 XBurial 2		☐ Removal from	n State			ition (Name of atory or other plac			ate		_ocation - Ci	•		
Ē	iit. Pag irtmer irtant injury		4 Donation 5				Ston		Cemeter					ne Mt.	_		
Ba	permi Depar Impor any ir once.		21. Signatore of Fune	September 100	ensee				Name and Addres  Ridgely							P.A.	
	Priysician,	0 3	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):												ween		
7	Medical Examiner				Due to	(or as a	consequer	nce of):									
	ed sit	Examiner	cause. Enter Underlyi	Cause (Disease or injury													
	cate be executed physician and the burial-transiti	Еха	that initiated events resulting in death) Las		c. Due to	(or as a	consequer	nce of):							+		
00	s be e ysiciar e burit	edical			d												
876	tificate ng phy as th	Med	IF FEMALE:														
. Box 687	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi	Physician/M	23b. Was decedent proint the past 12 mo	nths?		Birth 2		leath 3 🗌	Ectopic pregnanc Other (specify)	у				23d. Date of Month		*	Year
P.O.	requires that the dec been signed by the s should be detached	by P	Part II. Other significa	ant conditions	contributing to	death but	t not resulti	ing in the un	derlying cause giv	en in Part	1.	23e. Did to	obacco	use contribu	te to the	e cause of d	eath?
rds,	equire: een sig nould b	eted	Don	entre								1 🗆	Yes 2	No 3	☐ Prob	ably 4 🗍	Unknown
Division of Vital Records,	sician: The law r certificate has b irector, page 2 sk	Completed	25. Was case referred				9.5-					24a. Was autor perfo 1 Yes		prio dea	r to con th?	sy findings anpletion of c	available ause of
/Ita	siciar certil	To Be	examiner?	_	Hospital:	1 4:			Othe	r: Dear							
of/	Attending Physician: 7 or death. ector: After this certifice by the funeral director, c		27. Manner of Death		28a. Date		28	NOutpatient  Bb. Time of	28c. Injury	at		ne 5 🗆 Resid 8d. Describe h			Specify)		
on	endin sath. or; Aft he fur	fical	2 Accident	5 Pending Investigat	ion	ип, рау,	rear)	injury	M 1 □	? Yes 2 🗌	No						
28a. Date of injury (Month, Day, Year)  The property of the pr									t, factory, office		2	8f. Location (S City or Tow			r Rural I	Route Numb	oer,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A completed filled in by the fu	Medical	(Check 2 ∟	Medical Exa	miner: On the ba	sis of exa	mination ar	nd/or investic	cured at the time, lation, in my opinio	n, death oc	curred at t	he time, date a	nd place	e, and due to	the caus	se(s) and ma	nner stated.
	To the within To the compl	Σ	only one) 3 ∟ 29b. Signature and title		0			iowiedge, de	ath occurred at the		and place	$\overline{}$		te signed (IV	lonth, D	ay, Year)	
	20		30 Name and order	294	Asura can			(a) /Time 5 :	105	710	9 6		1	<del>'/-</del> Ju	1y 2	26, 20	)10
à	XI		30 Name and address	500	me	2	1118	Di	) met	10	m	Cher	he	~, ~	W)	2/0	019
	State Registra	Ģ.	31. Date filed (Month, I	UL 27	2010 32. F	Registrar's	s Signature	1. 4	ale								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND ITEM#8perFH, G906, 8/12/2010, WS
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** Robert SIMMS 6.15 PM 22 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** ST. Marys charlotte Hall Charlotte If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. April 29 1935 Year 1933 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months 1**∑** M 2□ F Washington DC 214 32 9208 75 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Maryland Prince George's Upper Marlboro 1 ☐ Yes 2 XX Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11100 Lynford Court 20772 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Korean 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 2 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Fireman Fire Department marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any lighty or other traumatic event, 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert H. Simms, Sr. Elvida Pometto ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert H. Simms, III (Son) 4380 Rock Court, Waldorf, MD 20602 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town State 4 □ Donation 5 □ Other (Specify) Resurrection Cemetery July 27, 2010 Clinton, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 21. Signature of Fan Surviv Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Preumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Pulmonary Sequentially list conditions Examiner If any, teaching to harredia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed physician and s the burial-trans Anoxic Encephalopathe Due to (or as a consequence of): Box 68760, Physician/Medical attending pl IF FEMALE: NA 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Dav 5 Other (specify) signed by the a P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Hypertension, Diabeto ficate has been sign, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hospital or Attending Physician: The performed? certificate 2 □ No 1 ☐Yes 2 12 No : After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 M Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural n 24 hours after death.

e Funeral Director: Afterely filled in by the fun 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 29a. Certifier sompletely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medi within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mD 7/23/2010 Thibands 00064324 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Santha, 100 Hospital word, Prince Frederick, MD, 20678

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 28 2010

ORIGINAL

32. Registrar's Signature

Deve B. parks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 8:10 P M Andrew Joseph Seger, Sr. Julv Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death t. Mary's Mary's Hospital
Security Number 16. Sex <u>.eonardtow</u>n 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M M 2 □ F (Month, Day, Months Hours Director 66 Maryland 213-42-9227 Dec. Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes XX No Maryland Charles Newburg 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20664 12210 Potomac View Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Was Deceue... Armed Forces? 1 X Yes 2 1964 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 X Married 1964 1968 1 ☐ Yes 2 X No Specify: 3 Divorced Specify: White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Plumber ACME Plumbing 10 th. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Cartha Grove Thomas Seger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If Item 27 any injury or other tr once. 12210 Potomac View Dr. Newburg, Maryland 20664 Elizabeth Seger/ Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Aug. 2, 2010 Cheltenham, MD. Maryland Vets' Cem. 21. Signature of Funeral Service Lie 22. Name and Address of Facility Huntt Funeral Home 3035 Old Washington Rd. Waldorf, MD. 20601 23a. Part 1. Enter the disease, or complications that caused the dearh. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only on cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ SEPSES Medical resulting in death) Due to (or as a consequence of) Examiner Z4 HOURS ASPERATION PNICUMONED Sequentially list conditions, if any sound cause. Enter Underlying Examine MONTUS Cause (Disease or linjury that initiated events ALTERED MKNTAI attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Pregnant at time of death 2 No the 9 Unknown ģ been signed the should be detailed Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 2 X No 3 ☐ Probably 4 ☐ Unknown ENPHYSEMA 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death?
1 Yes 2 No within 24 hours after death.

To the Funeral Director, After this certificate to completed filled in by the funeral director, page 2 X No 25. Was case referred to medical 8 26. Place of Death (Check only one) examiner? Other: 4 \(\subseteq\) Nursing Home 5 \(\subseteq\) Residence 6 \(\subseteq\) Other (Specify) 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide HOME Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 29b. Signature 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21093 R. GEBSON 2701 BOXMERERO, WTHERVELLE MP

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Mo

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JOSEPH

ANDREW

Registrar's Signatu

10-05575 Warren D. Smith

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State of Maryland / Department of Health and Mental Hygiene 2010 25195

		1- For State Registrar				Certific	cate of	Deatl	7			F	Reg. No	D.		
Physicia edical Exami		1. Decedent's Name (First, Mid Warren		Doug				mith				Date of Dea Month July 25, 2	Day 2010			3. Time of Death 1733 hrs
		4a. Facility Name (if not institut Anne Arundel Medic			number)		41	b. City, T Annar	own, or Lo Oolis	ocation o				c. County of Anne Ar	undel	
Funeral Director		5. Social Security Number 218-48-9801	6. Sex	M 2 F		In yrs. last b	irthday) Yrs.	If Unde Months	r 1 Year Days	If Under	Min,	8. Date of B 10/21			Foreig	hplace (State or n Maryland untry)
w any		Usual Residence of Decedent 10a. State 10b. County			10	c. City, Tow								-		10d. Inside City Limits  1 Yes 2 X No
Maryland r 28a-f show any ed at once.	Director	MD Anne 10e. Street and Number 1583 St. M		ndel	Road		An	napo 10f. Zip		ng			_	tizen of Wh	nat Coun	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyegiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho- injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status  1 X Never Married 2	Married	12. Was De	ecedent Ev Forces? 2 X		If Yes, specify Cuban, Mexican, Puerto Rican, e									can Indian, Black, White
36 in 72 hours aft  han "natural' dical Examine	Completed by	15. Decedent's Education (Sp Elementary/Secondary (0-12	ecify only	or Dates: / highest gra			Decedent's Usual Occupation (Give kind of work do during most of working life. DO NOT use retired)     Building Contractor							Kind of Bu		ndustry
1215-00; be filed with sntal Hygiene irked other t	Be	17. Father's Name (First, Middl David		150	nfiel			ith		Maı	rgare		Pa	uline		Zimmerly
MD 2' d 2 should lith and Mi n 27 is m2	T <sub>0</sub>	Maris P. Welborne / Sister 129 Elder Street, Cumberland, MD 2150									1502	2				
timore, t. Pages l an tment of Hea rtant: If ite		20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  4 Donation 5 Other Specify:  20b. Place of Disposition (Name of cemetery, crematory or other place)  Cumberland Crematory  20c. Location - City crematory or other place)  Cumberland Crematory  22c. Name and Address of Facility Alams Family Funeral							erla	nd, MD						
	į	23a. Part I. Enter the disease, of	dan	M	on took the	donth Do	40	)4 D∈	ecatu	ır St	reet	, Cumb	erl	and,	MD	21502 Approximate Interval
Physician Medical Examiner	2. ()	failure. List only one caus  Immediate Cause (Final diseas or condition resulting in death)	e on each e a.E		ion		not criter the	, mode o	dynig, s	ucii us cu	indide of t	ospiratory ar	1001, 51	iodi, or rice		Between Onset and Death
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus	b	ue to (or as												
nted d ansit	Examiner															
760, ficate be executed g physician and the burial - transit	<b>l</b> edical	UNPENDED AMENDED  IF FEMALE: 23d. If yes, outcome of pregnancy 23d. Date of deli										delivery				
Box 6876 e death certificat the attending phy ed for use as the	Physician/M	23b. Was decedent pregnant in past 12 months?	the nknown	1 Live	birth Inant at tim	e of death	2 Feta	al death er (Spec		Ectopic	pregnanc	;у 		Month	•	ay Year
s, P.O. B ires that the d signed by the	þ	Part II. Other significant cond	itions c	contributing	to death b	ut not resulti	ing in the un	derlying	cause giv	en in Par	t I.		_			the cause of death?
ords law requents been 2 should	Completed											24a. Was auto perfo	psy orm <u>ed</u> ?	p		copsy findings available completion of cause of s
tal Recional The	Bec	25. Was case referred to medic examiner?	—					2			Check on	ly one)				
Vit hysic r this o	10	1 ✓ Yes 2 No	Ho	spital: 1		2 V ER/						Home 5			Other:	
sion of vertending Ph death.  ctor: After t			nding estigation	FOUNI Jul 25,		FO 164	o. Time of Inj DUND: 45 hrs		-	s 2 🗸	No O	8d. Describe perating j	et ski	during e	electric	
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	4 Homicide det	uld not be ermined	(Specify	Bay	y - At home,					CI	or Town, hesapeake	State) Bay 3	8° 58.742	2 x 76° 2	ral Route Number, City 23.013, Anne Arunde
To the Ho within 24 To the Fu completely	Medical	(Check only	aminer: C		of examin	_		on, in my	opinion, d	death occ		ue to the cau he time, date	and p	lace, and d	ue to the	e cause(s)
5	N	Courage and title of certification of the courage of the courage of the certification of the	ler H	ell	Qa	·		290.	O.C.M					y 26, 20		nth, Day, Year)
noss		30. Name and address of personal Allan, MD A		t Medica	l Examir	ner 11	Penn S	treet, E	Baltimor	re, MD	21201					
St Regist	tate trar	31. Date filed (Month, Day, Year	10	32. F	Registrar's	Signature	wed									

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10:25P.M WMar JUTV 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Laurel Regional Hospital Laurel Social Security Number 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth Funeral Months Hours Min. 1 X M 2 □ F 82 Mayont/8 Day, 1928 215-20-3275 Wastrington, DC Director Usual Residence of Decedent 10b. County ms 23a or 28a-f shor must be notified at 10a State 10d. Inside City Limits 10c. City, Town or Location Director Prince George's Maryland Laurel 1 Nes 2 □ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7700 Cherry Lane 20707 United States items death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Examiner Black, White, etc. , or þ 1 Never Married 2 ☐ Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or ury or other traumatic event, the Medical Examir Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Hecht Company Salesman retail Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Barnett Sherman Tilly Weiner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances E. Fliss -niece 9202 Twin Hill Lane Laurel, Maryland 20708 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cometery, crematory or other place)

Mount Lebanon Cemetery 7/29/2010 1 Burial 2 Cremation 3 Removal from State Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Bonald Vies Borg Wardt Funeral Home, 4400 Powder Mill Road Beltsville, PA Maryland 20705 23a. Part 1. Enter the disease, or compile ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Sepsis disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (pisease or in jury that initiated events Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death 2 No 9 Unknown Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4X Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 XNc prior to completion of cause of 1 ☐ Yes 2X No ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2**X** No 1 🗌 Yes မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at wo<u>rk</u>? Certificate: 28d. Describe how injury occurred Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D55861 July 27, 2010 D

Registrar
DHMH 17 Rev 7/2009

State

Abdul Munim, M.D. LRH 7300 Van Dusen Road Laurel, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

28

rease Type of Fillit III black ilidelible lik. Elisale Ali Cop	pies Ale Legible.	
State of Maryland / Department of Health and Menta  Certificate of Death	I Hygiene	2510
Certificate of Death	Reg. No.	23131

	•	For State Registrar	olato of Maryland		rtificate of I	Death	ا ۱۰۰۰۱ ۱۰۰۰	Reg. No.	10	25197		
Physicia	n	1. Decedent's Name (First, Middle, La					2. Date of Dea	Day _	Year	3. Time of Death		
/Medic		JOSEPH	C. STERLING	j	4h City Town	Landin of Dooth	July 2			10:05 P M		
Examin	er	4a. Facility Name (If not institution, given 107 Hall Highway)	/e street and number)		4b. City, Town, or Location of Death Crisfield  4c. County of Death Somerset							
Funeral Director		5. Social Security Number 6. 8 220–28–1292	Sex 7. Age ( <i>In yrs. la</i> 1 ☑ M 2 ☐ F 79	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt Month Da 10/20/	1930		place (State or Foreign Tand		
and		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Lo	cation		-		1	0d. Inside City Limits		
e Maryla 8a-f sho	Director	Maryland Some	erset		Crisfiel	_d				1 XYes 2 No		
th with th	ral Dire	10e. Street and Number 107 Hall Highway	,		10f. Zip Code	21817		10g. Citizen o	J.S.A.	itry?		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is indical Evanture. Let be milited a sonce.	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Sayes 2 No 195 If Yes, Give Year or Dates: 1954	2-	Was Decedent of H If Yes, specify Cuba 1 □Yes 2 → No	llspanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	ican, etc.) 14. Hace - Al Black, WI				
72 hc	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	ing	16b. Kind of	Business/Ind	dustry			
within lene. than	дшс	Elementary/Secondary (0-12)	College (1-4or 5+) 5 +		wner	Seafood						
filed I Hygi other ent, t	Be C	17. Father's Name (First, Middle, Las				e (First, Middle,	Maiden Surna	ame)				
Aenta Venta rked ric ev	10 B	Arlie Graham Ste	erling			Ada V	irginia	Cochra	ane			
2 shou and h is ma auma		19a. Informant's Name/Relationship				and Number or Rui				) Code)		
and Health	}	Ruth Ellen Sterl				- Crisfi	eld, MD	2181'		State		
. Pages 1 tment of H tant: If ite jury or ot		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	fy) Sunn	yridge 1	sition (Name of matory or other place Memorial Pa	rk   07/3	1/2010		ield,			
permit. Departn Importa any inju		21. Signature of Funeral Service Line	well	Br	2. Name and Addre	ss of Facility Sons Fun n St. — C	eral Ho	me d. MD	21817	7		
Physician		Robert H. Brac 23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	nplications that caused the death	. Do not ent	ter the mode of dyir	ng, such as cardiac			21017	Approximate Interval Between Onset and Death		
/Medical Examiner		disease or condition resulting in death)	a. Due to (or as a consequ	ence of):	ies vi							
uted 1 Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to (or as a consequ	ence of):								
be exectician and ourial-tra	e Exa	that initiated events resulting in death) Last	Due to (or as a consequ	ence of):								
ficate physi s the t	Medical		d									
	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	☐ Ectopic pregnanc ☐ Other <i>(specify)</i> _	у			23d. Date of delivery Month Day Year					
uires that signed b d be deta	þ	Part II. Other significant conditions	contributing to death but not resu	Iting in the u	nderlying cause giv	en in Part I.	23e. Did t	~		the cause of death?		
law req as beer 2 shou	Completed						24a. Was		b. Were auto	opsy findings available		
: The cate h	ပ္ပ							2 No	death? 1 □ Yes	2 No		
certifi rector,	Be	25. Was case referred to medical examiner?	Hospital:		oth SCIDOA Oth	26. Place of Dear	1					
Phys	٠ <u>.</u>	1 ☐ Yes No  27. Manner of Death	28a. Date of Injury	ER/Outpatier 28b. Time o	III 3 LI DOA	4 LI Nursing H	ome 5 Resi 28d. Describe	dence 6 0		fy)		
th. : Afte	ition	Natural 5 Pending investigation	(Month, Day, Year)	injury		kí?  Yes 2 □ No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
al or Atter after dea I Director d in by the	Certification: To	3 Suicide 6 Could not t 4 Homicide determined		me, farm, str	reet, factory, office		28f. Location ( City or To		mber or Run	al Route Number,		
e Hospita 24 hours e Funera letely fille	Medical C	29a. Certifier Certifying P	hysician: To the best of my know miner: On the basis of examinat and manner stated.	wledge, deat ion and/or in	th occurred at the ti	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and date and plac	manner as ce, and due t	stated. to the cause(s)		
To the within to the comp	Me	29h Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)										
		30. Name and address of person who	completed cause of death (Item	23a) (Type,	Print) Po Bos	1733	Salist	MI	2/8	302		
Sta Registra		31. Date filed (Month, Day, Year)	2010 32. Registrar's Signat	u/e	tores.		(	)				

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

## Page Not Found

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 3:20 PM Carrie V. Taylor July Medical Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Regional George's Hospita aure Prince If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🛣 F Davs Hours Min (Month, Day, Year) September 26, 1927 Country)
D.C. Director 220-28-5750 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene.

7 is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No **Owings** MD Calvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1024 E. Mt. Harmony Road USA 20736 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 ₩ Widowed 4 □ Divorced Completed Black Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Someone Else's Home Housekeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Edna Emerson Walter H. Johnson other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1024 E. Mt. Harmony Road, Owings, MD 20736 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Sterling B. Taylor - son 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Ward's Mem. UMC Cemetery July 28, 2010 Owings, MD 1 

■ Burial 2 

□ Cremation 3 

□ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sewell Funeral Home, P.A. 21. Signature of Funeral Service Licenses 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardio-Pulmonary Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the attending physician and hed for use as the burial-transit Pneumonia that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Pregnant at time of death cate has been signed by the a page 2 should be detached 1 ☐ Yes ∠y 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an • Hospital or Attending Physician: The law 24 hours after death.
• Funeral Director: After this certificate has I autonsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Hospital Other: 2 No ပ္ 1 Yes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) | X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number determined City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD D60936 July 21, 2010 an 7300 Van Dusen Road 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Abdul Tak, M.D.

Laurel Regional Hospital

Registrars Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25200 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10:35 P.M TREMBACH JOSEPH 2010 JULY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Allegany Nursing & Rehab. Cumberland Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours Min. 176-24-6598 79 **Director** 03/02/193 Pennsylvania Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at Director WV Berkeley Springs 1 X Yes 2 No Morgan 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 15411 6 Restridge Drive, Apt. A U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian r than "natural", or iter the Medical Examiner Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married ğ 1 Yes 2 □ No If Yes, Give Year or Dates. ■ 5 Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Completed 3 Widowed 4 Divorced White 152-154 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Heavy Construction Operating Engineer other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked ot 2 Unknown Mike Trembach permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25 Hillside Avenue, Northport, NY Craig A. Trembach / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 07/27/2010 Northport, NY 4 ☐ Domation 5 ☐ Other (Specify) Northport Rural Cem. 22. Name and Address of Facility 21. Signature of Funeral Service License Upchurch Funeral Home, P.A. 202 Greene Street, Cumberland, MD 21502 23a. Par 1. Enter in disease, ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ships, k, or hear failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final METASTATIC Physician/ MOS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, cause (Disease or linjury Due to (or as a consequence of, attending physician and for use as the burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death , the g Unknown 9 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ has been sig Completed 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page perform death? certificate 1 ☐ Yes 2 ☐ No 20 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2 11/00 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at e Hospital or Attending Pl 124 hours after death. e Funeral Director: After the pleted filled in by the funera 28d. Describe how injury occurred Certificate: Natural injury 5 Pending 1 Yes 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral C completed filled in the filled in t Medical 29a. Certifier 🗓 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 10 d cause of death (Item 23a) (Type Name and address of person who complet Glenn St. Cumberland,

State Registrar

nas

68760

Box (

P.0.

Records,

Division of Vital

rvera

Registrar's Signature

10-05355	
Marlon Antonio Tinno	n
1	- F
	Reg

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

arlon Antonio	Tinr	on S	tate of Maryla		artment o				ygiene	20	10	2520	
Physici	an/	Registrar  1. Decedent's Name (First, Midd	lle,Last)		Tuncate O	Death	-		2. Date of Dea	teg. No.		3. Time of Death	
ledical Exami		Marlon Anton:							Month July 17, 2	Day Yes		2328 hrs	
		4a. Facility Name (if not instituti		umber)		4b. City, Town	, or Loc	ation of Death		4c. County	of Death		
		Shady Grove Adventi	st Hospital			Rockville				Montgor	•		
Funeral		5. Social Security Number UNK	6. Sex	7. Age (In yrs.	last birthday)		If Under 1 Year   If Under 24Hrs.   8. Date of Birth(MM/DD/YYYY)   9. Birthpla Months Days Hours Min.   Foreign						
Director			1 M 2 F	23	Yrs		Juys	Tiodis	SEP 23	3, 1986	, 1986 Country) MI		
any		Usual Residence of Decedent  10a. State 10b. County		10c City	, Town or Locat	ion						10d. Inside City Limits	
<b>*</b> .			gomery		ithersb							1 Yes 2 No	
daryland 28a-f show i at once.	cto	10e. Street and Number	30mery	Ga	itthersh	10f. Zip Cod	le			l0g. Čitizen of WI		21	
he Ma 1 or 23 iffied	Director	915 Clopper H	Road, #A-2		20878					United State			
with 1 ns 23g	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-											an Indian, Black,	
death or iter	Armed Forces?  If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  White, etc.										e, etc.		
after	by F		vorced If Yes, Give Yes or Dates:		1 🗌	Yes 2X					B1a		
hours natu		15. Decedent's Education (Spe				t's Usual Occu ost of working				16b. Kind of Bu	isiness/In	dustry	
36 nin 72 E. than '	ple	Elementary/Secondary (0-12)  G	College (1	1-4 OF 5+)	UNK					UNK			
d with	Completed	17. Father's Name (First, Middle	, Last)		OTTE		18.N	/lother's Name	(First, Middle, I	Maiden Surname	)		
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Be (	UNK					7	Trisha	Ann For	:d			
221 hould is man	ဥ	19a. Informant's Name/Relations			1					mber, City or Tow	n, State, 2	Zip Code)	
MD nd 2 sho alth and on 27 is		Trisha Ford I	ryce / mo		52 W.				ling, N	Y 12564	O't T	Otata	
Baltimore, permit. Pages 1 an Department of He Important: If ite		1 Burial 2 X Cremation	n 3 Removal fr		crematory or otl		cemete	ary,	Date	20c. Location -	City or I	own, state	
timent Tant:		4 Donation 5 Other S		At	lantic	Cremato	ory	07/	22/2010	Glen B	urnie	e, MD	
Ball Permit Depar Impor		21. Signature of Funeral Service	Licensee	W00	22 1	hibadea	ess of F au N	acility Iortuar	y Servi	ce, p.a ourg, MD	•		
Physician		23a. Pap I. Emer the disease, or	complications that c	M00 aused the death	n. Do not enter th	Park A ne mode of dyi	Aver ng, suci	nue, Ga has cardiac o	r respiratory arr	est, shock, or he	208. art	Approximate Interval	
/Medical		failure. List only one cause	0	ounds (2) of	Head (1) ar	nd Chest (1	)					Between Onset and Death	
Examiner		Immediate Cause (Final disease or condition resulting in death)		consequence of		ia chest (1	,						
	_	Sequentially list conditions,	b										
	in	if any, leading to immediate cause. Enter Underlying Cause		consequence o	of);								
b =	Examiner	(Disease or injury that initiated events resulting in death) Last		consequence o	of):								
execute ian and ial - transit	dical E	UNPENDED	dAMENDED							<del>.</del>			
_ 8 5 5	Med	IF FEMALE:		outcome of preg	inancv					23d. Date of	delivery		
687 ertifica ding p	sician/Me	23b. Was decedent pregnant in the past 12 months?	ne 1 Live b	irth	2 Fe	al death	з 🔲 Е	ctopic pregna	ncy	Month	Da	y Year	
Box 68760, death certificate bhe attending physic of for use as the but	sici	1 Yes 2 No 9 Un	known g unkno	ant at time of de	eath 5 Otl	ner (Specify)							
D. B.	Phy	Part II. Other significant condit			esulting in the u	nderlying caus	se given	in Part I.	23e. Did to	bacco use contri	bute to th	e cause of death?	
i, P.O ires that to signed by I be detac	ğ								1 Yes	3 2 No 3	Proba	bly 4 🗹 Unknown	
Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should the fine of the funeral director.	Completed								24a. Was			psy findings available	
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tal Rection: The certificate ector, page		25. Was case referred to medica	1		<del></del>	26.Pla	ace of D	Death (Check o			103	2 110	
Vita	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 1	npatient 2 🗸	ER/Outpatient	3 DOA	Othe	er4 Nursin	g Home 5	Residence 6	Other:		
l of ing Pl After funera		27. Manner of Death	28a. Date FOUND	of Injury Day,Year)	28b. Time of Ir FOUND:	-	njury at		28d. Describe I Subjact sho	now injury occurre	ed		
Sior titend death. ctor: y the j	äti	Pen	stigation Jul 17, 2	2010	2250 hrs			2 No					
Divis after Dire	Certification:	doto	a not be		ome, farm, stree	t, factory, offic	e buildii	-	or Town, S	tate)		Route Number, City	
Cospital hours		4 Momicide	(0,000)/	Bus Stop			-1-1			fe Road , Gaith		· · · · · · · · · · · · · · · · · · ·	
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bi	Medical	(Check only	hysician: To the bes miner:On the basis o	of examination a	-								
To rou	Mec	29b. Signature and title of certific	and manner si	tated.		29c. Lice	ense nu	mber		29d. Date signe	ed (Monti	h, Day, Year)	
		TII W	1 1/ a	1-1	3	0.0	C.M.E	DC	ME	July 18, 20	10		
	ŀ	30. Name and address of person	who completed caus	se of death (Item	23a)	,							
		Theodore M. King, Jr.		nt Medical E	Examiner	111 Penn 9	Street	, Baltimore	e, MD 21201	l			
St Regist	ate	31. Date filed (Month, Day, Year)		gistrar's Signatu	re face	^							
regisi	1541	JUL WUL	OTO APPROX		4 20								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Thornton Jr. John Leonard 37 2010 Medical Town, or Location of Death 4c. County of Death **Examiner** 4b. City, 15 Nicomic If Under 1 Year | If Under 24 Hrs. Security Number 7. Age (In yrs. last birthday 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Sex. 1 ☐ M 2 ☐ F Hours 10/14/1942 Maryland 67 215-38-1651 Director Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County injury or other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No Wicomico Salisbury Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral items 23a 21804 USA 604 Calloway St. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces? should be filed within 72 hours after d and Mental Hygiene. is marked other than "natural", or i ò 1 Never Married 2 Married 2 No JOhn I NUCUTA Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: white If Yes. Give 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) na n Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Marie Sophie Brzsoka John Leonard Thornton Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28875 Adkins Rd., Delmar, MD 21875 Joyce Cathell/sister Department of Health ar Important: If item 27 is any injury or other trau 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Surer (Specify) Salisbury Crematory Salisbury, MD 4 Donation 5 Other (Specify) HOTTOWAY Fufferal Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 CFSP 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ LUNG CANCER MRTASTATIC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): physician a Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav 5 Other (specify) Pregnant at time of death the Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Division of Vital Records, cate has been sig ; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ♣ Ro 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence Other (Specify) HOSPICE ဂ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5  $\square$  Pending work? 1 ☐ Yes 2 ☐ No Natural Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. pleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Dav. Year, D0058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21802 31. Date filed (Month egistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7:00PM JOAN TOWNSEND S. 2010 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Dalisburg Viccom Dice at ten If Under 1 Year If Under 24 His 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🔀 F Months Hours 08/28/1934 Mary I and 217-30-8364 75 Director Usual Residence of Decedent or 28a-f shov notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director Maryland Somerset Princess Anne 1 🗌 Yes 2 🏻 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ŏ "natural", or items 23a o Funeral 30612 Antioch Avenue 21853 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc þ 1 Never Married 2 Married 1 Yes 2 🔀 No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🔀 No Specify: Specify: 3 ☒ Widowed 4 ☐ Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Seafood Processor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Vaughn Evans Ella Estelle Shores 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) O. Box 103 - Deal Island, Kay Daniels (Sister) MD20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State St. Pauls Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 07/24/2010 Wenona, MD 21. Signature of Puncial Service Lic Robert H. Bradshaw, or. 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARCINOMA LIURA Physician/ MALIGNANT disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes No
9 Unknown Month Year Day Pregnant at time of death 9 Unknown P.O. F Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2/ Yes EL Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence Other (Specify HOSPICA မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred Certificate: 28b. Time of 28c. Injury at Natural 5 Pending 1 🗌 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GALLIAN

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July Physician/ 28 10:54 AM William Austin Wroten, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Memorial Hospital Calvert Prince Frederick Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ₭ M 2 🗆 F (Month, Day, Year) 07/27/1934 Mary land 218-30-8141 76 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 H No Maryland 1 Solomons Calvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14326 Sedwick Avenue 20688 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian þ 1 Never Married 2 Married 1 Yes 2
If Yes, Give ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Waterman Boat Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pauline Morgan William Austin Wroten, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Dean Wroten / Wife P.O. Box 141, Solomons, MD 20688 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 To Cremation 3 Demoval from State 4 Donation 5 Other (Specify) Metropolitan Crematory 07/29/2010 Alexandria, Virginia 21. Signature of Funeral Service License 22. Name and Address of Facility Rausch Funeral Home, P.A. P.O. Box 600, Lusby, Maryland 20657 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final - γγsician/ Medical disease or condition resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Year signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes cate has been sig Completed Chronic Kidney disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 Inpatient 2 KeR/Outpatient 3 IDOA ဂ္ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this a completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Investigation 6 Could not be 1 Yes 2 No Accident Suicide
Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D52242 July 28, 2010

State Registrar Joseph John Barth, III, MD, 110 Hospital Rd, Suite 310, Prince Frederick, MD 20678

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

32. Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [ ] 25205 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July Earl W. Wingate 2010 8:00 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2540 Kensington Garden #306 Ellicott City Howard Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🛛 M 2 🗆 Min. 04/10/1924 Director 220-52-7042 86 MD Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 XNo Howard Ellicott City MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2540 Kensington Garden 21043 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 

XYes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 XNo Specify: 3 ☐ Widowed 4 ☐ Divorced "natural" Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) . Page 1 and 2 should be filed within 72 rment of Health and Mental Hygiene. tant: If item 27 is marked other than ' jury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Sales Television 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nathaniel Wingate Harriett Weitzel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eileen Wingate - wife 2540 Kensington Garden #306 Ellicott City, MD 21043 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of
Important: If it
any injury or o
once. cemetery, crematory or other place) 1 Ϫ Burial 2 🗆 <u>Crem</u>ation 3 🗆 📙 moval from State 4 Donation 5 Other (Specify) Woodlawn Cemetery 107/31/2010 Woodlawn, MD 21. Signature of Emral Service M01411 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a, Part 1. Enter the dise Immediate Cause (Final ASHO Physician/ disease or condition Medical resulting in death) Examiner LENAl Failine Sequentially list conditions, if any hading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and ated filled in by the Innetal director, page 2 should be detached for use as the burial-transit ated filled in by the Innetal director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year 9 Unknown NA. 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 🗆 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cartifying Nurse/Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29d. Date signed (Mgnth, Day, Year) of person who completed cause of death (Item 23a) (Typer Print) 30. Name and add 512 State

Registrar

		Please Type or Print in B State of Maryland				-	_	le.		
	-	For State of Maryland  State of Maryland Registrar		tificate of Deati			eg. No. 2 N	0 25200		
		Negestral     Decedent's Name (First, Middle, Last)				2. Date of Deat	h	3. Time of Death		
Physician Medic		Jacqueline Mary Wilson				On 2				
Examine	er	4a. Facility Name (if not institution, give street and number)  46 W. Water St.		4b. City, Town, or Location Smithsb			4c. County of D	Death ington		
Funeral Director		5. Social Security Number $215-26-2130$ 6. Sex $1 \square$ M $2 \times 7$ F $7$ Age (In yrs. lass	t birthday) Yrs.	If Under 1 Year If Under 1 Months Days Hour	der 24 Hrs. rs Min.	8. Date of Birth (Month, Day,	Year)	9. Birthplace (State or Foreign Country)		
		Usual Residence of Decedent	Town or Lo			12/1/	/19311_	MD  10d. Inside City Limits		
faryland 3a-f sh tified a	ecto	10a. State MD Washington 10c. City,		hsburg				Yes 2 No		
ith the N 23a or 2 st be no	Funeral Director	10e. Street and Number 46 W. Water St.		10f. Zip Code 21 783		1	0g. Citizen of What	t Country?		
eath w	nne	11. Marital Status 12. Was Decedent Ever in U.S.	13. V	Vas Decedent of Hispanic	Origin? (Spe	cify Yes or No-		American Indian,		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	d by	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced  Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates.		f Yes, specify Cuban, Mexi		Rican, etc.)		White, etc. White		
2 hours	Completed by	15. Decedent's Education (Specify only highest grade completed)	(Give I	lent's Usual Occupation kind of work done during n	nost of worki	ng	16b. Kind of Busine	ess Industry		
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nd Mer mark mark		George B M Wilson  19a. Informant's Name/Relationship (Type, Print)	City or Town, State	;, Zip Code)						
nd 2 sh lealth a m 27 is her trai		Betty Wilson(Sister)	333	Coneflowe	r Dr.	, Will	iamspor	t, MD		
age 1 a ent of H nt: If ite y or ott		Cer	netery cren	sition (Name of natory or other place)  urg Cremat	i		20c. Location - City O Smith			
permit. F Departm Importa any inju		21. Signature of Funeral Service Uicensee		Name and Address of Fa 31 E. Main						
44 = 40		23a Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.						MD 21769  Approximate Interval Between		
Physician/		Immediate Cause (Final disease or condition	. ca	Dymord in	pan	rey_		Onset and Death		
Medical Examiner		resulting in death)  Due to (or as a conseque	nce of):	Mar of d	Bulli.	0		14-24-7		
n #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	nce of):	· · · · · ·	week			133		
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medio	1		Other (specify)			Month	Day Year		
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he law rte has l	dmo					autops perforr	sy prior med? deat	r to completion of cause of		
cian: T ertifica ector, p	Be	25. Was case referred to medical examiner?		26. Place of I	· · · · · · · · · · · · · · · · · · ·	( only one)				
Physi er this c	e: To	27. Manner of Death 28a, Date of injury 2	8b. Time of	28c. Injury at			ence 6 Other (Sow Injury occurred	ipecify)		
tending leath. or: Afte the fun	Certificate:	1 Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	injury	work? M 1 ☐ Yes 2						
al or At s after o l Direct	Cert	4 ☐ Homicide determined determined determined building, etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location (St. City or Town		r Rural Route Number,		
Hospita 24 hours Funera	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowler (Check 2 Medical Examiner: On the basis of examination and the control of the basis of examination and the control of the basis of examination and the control of the basis of examination and the control of the basis of examination and the control of the basis of examination and the control of the basis of the basis of examination and the basis of the bas	and/or invest	tigation, in my opinion, deat	th occurred at	the time, date an	d place, and due to	the cause(s) and manner stated.		
To the within To the comple	Σ	only one) 3 Certifying Nurse Practioner: To the best of my leads to the best of the best o	knowleage, g	29c. License numb	er	2	9d. Date signed (M	fonth, Day, Year)		
UF		La Callangui	220) / 5 - 5		576	00	3/2/10			
2		30. Name and address of person who completed cause of death (Item 2 2 9) 1 Left Sur BIVIL		Mr port	MD	2178	3.3			
Stat Registra		31. Date filed (Month, Day, Year) 32. Fegistrar's Signatu		arked						

Amended #18, 08/02/10, nls, per FD, Allegany Co. Amended #22, nls, per FD, 07/28/10, Allegany Co. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2010 25207 10-05515 Michael Anthony Watts Certificate of Death Reg. No 2. Date of Death 3. Time of Death Decedent's Name (First, Middle,Last) Physician/ Month Day July 23, 2010 1418 hrs ুবical Examiner MICHAEL ANTHONY WATTS 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Allegany Lovers Leap/Will's Mountain Cumberland If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Davs Hours Min. Director Country) WV 05/26/1991 1 X M 2 F 19 233-39-6639 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 V No items 23a or 28a-f show **KEYSER** MINERAL Baltimore, MD 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of St land 2 should be filed within 472 hours after death with the Maryland Important. If item 77 is marked other than "natural", or items 23a or 28a-f sho injury or other trannatic event. the Modical Fromming. WW Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 26726 ROUTE 2, BOX 122B 13. Was Decedent of Hispanic Origin? ( Specify Yes or No 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces 1 X Never Married 2 Married 2 X No 1 Yes WHITE If Yes, Give Year 1 Yes 2 X No specify: 3 Widowed 4 Divorced ⋧ 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) RETAIL GROCERY STORE MEAT ROOM CLEANER 17. Father's Name (First, Middle, Last) Be ANTHONY WAYNE WATTS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 26726 ROUTE 2, BOX 122B, KEYSER, WV / MOTHER MICHELLE DEETZ 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State FORT ASHBY, WV FORT ASHBY CEMETERY 07/30/2010 4 Donation 5 Other Specify: P.O. BOX 1260 P.O. BOX 1260 P.O. BOX 1260 P.O. BOX 1260 P.O. BOX 1260 P.O. BOX 1260 Signature of Funeral Service Licensee 23a. Part | Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval Physician Between Onset and filure, List only one cause on each line. Death /Medical a. Intraoral Shotgun Wound Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Physician/Medical AMENDED UNPENDED attending physician or use as the burial Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Day 1 Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy this certificate has I death? performed? ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: within 24 hours after death. Be examiner? Other Nursing Home 5 Residence 6 🗸 Other Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 1 Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day,Year) FOUND: 28c. Injury at Work? 28b. Time of Injury After 1 27. Manner of Death Certification: Subject shot self FOUND: Natural 1 Yes 2 V No t Funeral Director: Pending Jul 23, 2010 1418 hrs Accident 2 Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 V Suicide 6 Could not be or Town, State) Lovers Leap/Will's Mountain, Cumberland, MD determined (Specify) Wooded Area Mountain Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only). Medical 2 / Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certi-8 July 24, 2010 O.C.M.E. カム 30. Name and address of person who completed cause of death (Item 23a) OCME Mary G. Ripple MD. **Deputy Chief Medical Examiner** 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 OCME 2006

State Registrar Day Year 28

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2010 8:30 P M August 9, Richard Henry Arndts /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Oak Crest Village Parkville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 13, 1 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 🛛 M 2 🗆 F 83 1927 139-20-8281 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show ir than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 No Director Maryland Baltimore Parkville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 8832 Walther Blvd. RG-105 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Communications 04 Mechanical Engineer is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event Be Elizabeth Rudolph Arndts 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3198 Winter Drive, Westminster, MD 21157 Randy M. Arndts/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 8/14/10 1 💹 Burial 2 □ Cremation 3 □ Removal from State 5 Other (Specify) Dulaney Valley Memorial Gardens Timonium, Maryland an W. Clary 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc. Bryan W. 10 W. Padonia Road, Timonium, MD 23a. Par . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Hypertensive Cordiovosalor Disease Immediate Cause (Fi) al **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause, leaded or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-tran Due to (or as a consequence of): Physician/Medical attending p as If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Dav 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) □Yes 2□No 9 Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 9 Reurodegenerative 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 □ Yes 2 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

ne Funeral Director: A
pletely filled in by the fu 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hou To the Funer completely fii Medical KNP 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number R171944 o completed cause of death (Item 23a) (Type, Print) Michealle G. Harrison
31. Date filed (Month, Day, Year)
AUG 12 2010 8800 Walther Blvd, Parkville, MD 21234 CRNP MSN State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#23a, pt1,11,26,28a-f, perME,G906,8/27/2010,WS

State of Maryland / Department of Health and Mental Hygiene 2 0 1 0 25209 State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death George F. Arner Physician/ August 6 ay 2010 Year 6:45 AMMedical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 5401 Moorland Lane Bethesda If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 1 M 2 □ F 9. Birthplace (State or Foreign Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months Davs Hours Aug. Pay, Year 52 Mary Tand 58 Director 579-64-5351 Usual Residence of Decedent 28a-f show should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1 🗌 Yes 2 🏝 No Maryland Montgomery Bethesda 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 5401 Moorland Lane 20814 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔼 No Black, White, etc. Completed by 1 🛮 Never Married 2 🗆 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Tennis Courts Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Frederick B. Arner Phyllis Benson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Robert L. Arner/Brother 1925 Ridge Hollow Road, Edinburg, Virginia 22824 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State August 7, 2010 Montgomery Crematorium, Inc. 1 Burial 2 Cremation 3 Removal from State Bethesda, Maryland 4 Donation 5 Other (Specify) Bethesda-Chevy 21. Signature of Fineral Service Licenses Robert A. Pumphrey Funeral Home/ 7557 Wisconsin Ave., Bethesda, Maryland 20814-3501 M00198 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Cutting Wounds of Wrists Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant 9 Unknown Month Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Lung and Spinal Cancer 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn Yes 2 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner?

1 ✓ Yes 2 ☐ No 26. Place of Death (Check only one) Be 4 ☐ Nursing Home State once 6 ₹ Other (Specify) At Scene Hospital: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury Pear) August 6, 2010 4:00 A. M 28c. Injury at ■ work? 1 □ Yes 28d. Describe how injury occurre Subject cut wrists Certificate: 27. Manner of Death 1 
Natural 5 Pending Self-Inflicted 2 🛛 No Investigation Accident 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

At Home

Driveway 28f. Location (Street and Number or Rural Route Number 20814 City or Town, State) 5401 Moorland Lane, Bethesda, MD determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8/ 10 6 NO 22018

DHMH 17 Rev 7/2009

State Registrar 0

Registrar's Signature

Tola

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) AUG 12 Betsy Ballard, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10:50 am Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner atonsvil Itimore HAVEN DY SINCIT 8. Date of Birth (Month, Day, Year) Feb. 3, 1946 Social Security Number Age (In yrs last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Mary Land Director 214-44-9014 64 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Baltimore Maryland N/A 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21230 1828 Jackson Street USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Yes 2 K No þ 1 Never Married 2 Married Maryland 21215-0036 ☐ Yes 2X No Specify Completed Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Meonce. Elementary/Seconday (0-12) College (1-4 or 5+) Security Title 0 Office Receptionist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Burkhardt Elsie Irvin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larae Armiger (Daughter) 7908 Della Rosa Court, Pasadena, Maryland 21122 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 A Cremation 3 Removal from State 8/10/10 Baltimore, Maryland Bayview Crematory, Inc. 4 ☐ Donation 5 ☐ Other (Specify) permit. 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 21. Signature of Fundant Virvice Licensee Kevin E Ecker 130 East Fort Ave., Baltimore, Maryland 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a cons Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to for as a consequence teen signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnan 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 month Month Day Year 1 Yes 2 D Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available 24a. Was an within 24 hours after death.

To the Funeral Director: After this certifica e has be autopsy performed? 1 Tyes To Be ( 25. Was case referred to me 26. Place of Death (C) examiner? Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner g Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Naturai 5 Pending 1 🗌 Yes 2 🔲 No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier ertifying Physician; To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar 30. Name and address of person who completed

31. Date filed (Month, Day, Year)

Print)

cause of death (Item 23a) (Type,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh 9906 8-12-10 yt State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 13:55 <sup>™</sup> JoAnn Bryan 08 2010 /Medical 80 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Towson Baltimore Genesis Nursing Home If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 8981 Months Hours Min 1 □ M 2 🔀 F Director 220-94<del>-8984</del> 67 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at Director 1 ☐ Yes 2 X No Baltimore Cockeysville MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10205 Sunny Lake Place Apt F 21030 U.S.A. Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify Specify: Completed by Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Quality Control Dept. Red Cross <u>12th grade</u> na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Rosiland Ford Milton Bryan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cockeysville 10205 Sunny Lake Place Apt F. Jasmine Ivy-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) On-Site 8/12/2010 Baltimore, Md 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
March F/H West U. STU 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death 23a. Par J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s ock, or heart failure. List only one cause on each line. Immediate Cause (Final discase or condition resulting in death) **Physician** ENCEPH ALOPA THY /Medical Due to (or as a consequence of): Examiner SUB ARACHNOID HEMORRHAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed ANEURYEN sician and burial-trans Due to (or as a consequence of) physician s the burial Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a Ö 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ SEIZURES 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate ha completely filled in by the funeral director, page 2 No Vital 1 □Yes 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No of Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manual of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certiffer 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only (bne 29h./Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AUGUST 10,2010 D0060560 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 THEREPAL 9106, PHILAD ELIHIA #208 23 BALLIMORE, MD 31. Date filed (Month, Day, Year) 32. Reastrar Signature State AUG 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ FRANKLIN BASTA AUGUST <sup>9</sup> 201°0° G. 1:10 ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CARROLL 5245 SHAFFER MILL ROAD LINEBORO Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 220 09 2751 1 🙀 M 2 🗆 F 89 Hours Min. 0 3 19nth, Pay 1 9 2 1 PENNSYLVANIA Director Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director MD CARROLL LINEBORO 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 23a Funeral filed within 72 hours after death with 21088 5245 SHAFFER MILL ROAD USA "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give , O. Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 ☐XNo Specify: 3 → Widowed 4 □ Divorced Specify: Completed WW II Year or Dates Page 1 and 2 should be merow....
Iment of Health and Mental Hygiene.
The marked other than "natura" and "item 27 is marked other than "natura" avent, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) LEVER BROTHERS 7th SUPERVISOR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MICHAEL BASTA ANNA BELLMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5245 SHAFFER MILL RD LINEBORO, MD 21088 EDWARD BASTA Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State GARDENS OF FAITH 08/13/10 BALTIMORE, MD 4 ☐ Donation 5 🛛 Other (Specify) FNTOMEMENT 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTIMORE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical (or as a sequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Dav Pregnant at time of death Yes 2 No the 9 Unknown Division of Vital Records, P.O. ģ been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy Director: After this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ည 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 IDOA 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral or Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending injury Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 29d. Date sighed (Month, Day, Year) 5569 10 23a) (Type, Print) icemann cis 31. Date filed (Month, Day, Year State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2010 Year **Physician** Month August 11, Bohle 6:55 Ам Evelyn /Medical **Examiner** 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A Johns Hopkins Bayview Center Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours Days 1 □ M 2 💢 F 212-26-0419 Yrs. Director 80 September 19,1929 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location f show 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shortraumatic event, the Medical Examinational by nother at Director Middle River 1 ☐ Yes 2 No Maryland Baltimore filed within 72 hours after death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 USA 14 Barbie Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 3altimore, Maryland 21215-0036 1 □Yes 2√2 No Specify: White 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Own Home Housewife 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna Kwiatkowski Walter Kalwa 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Barbie Court, Middle River, Maryland 21220 permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tra once. <u>Gustave</u> Bohle Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State August 14. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery Baltimore, Maryland 2010 ign sure of fluneral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 23a. Part 1. Enter the disease of complications that caused the death of not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician -2 W /Medical resulting in death) Due to (or as a consequence of): Examiner ronon Krown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is its lead to the cause). Examiner Due to (or as a consequence of): The law requires that the death certificate be executed as the burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical attending IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the a d be detached for 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, <u>\$</u> Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No certificate 2 No 1 □ Yes 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2. No 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 24 hours after death.

Funeral Director: After this letely filled in by the funeral dir in by the funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manyfer of Death 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 11 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Deertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier (Check only one)

within 2 To the I the

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

NO



**ORIGINAL** 

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Year 2010 August 3:20 ДМ PEGGY BOWIE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Age (In yrs. last birthday) 219-36-3336 Hours Month, Day, Country) MD. Ø Director show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. fant, If item 27 is marked other than "natural", or items 23a or 28a-f shor jury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director FREDERICK MD RUDORICK 1 Yes 2 ☐ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? HILDEBRAND 04 Funeral RD 5807 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 I No Specify: Specify: BLACK 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) NATIONAL INST. Elementary/Seconday (0-12) College (1-4 or 5+) TECHICIAN BIO. LAB OF NCALTH ZYVS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည HENSON GWENDOLYN BOLDEN CHARLES C. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5807 HILDEBRAND RD FROERICK MD 21704 5807 HILDEBRAND RD CHARLENE permit. Page 1 and 2 Department of Health Important; If item 27 any injury or other tr Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1. Burial 2 Cremation 3 Removal from State Au6,7,2010 FREDERICK FAIRVIEW Com. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice 19e 22, Name and Address of Facility GARY L. ROLLINS FUN. Home SOUTH ST FREDERICK MD ZITOI 110 WEST 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to in recliate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine u poten sion To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and tor. After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-tran Due to (o as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 🔀 No မှ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work Natural 5 Pending 1 Yes 2  $\square$  No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature 29d. Date signed (Month, Day, Year) D0063256 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

RAMANI

31. Date filed (Month, Day, Year)

NOKKU

400 W

32. Registrar's Signature

7th St

Frederick, ma

10-05926 Artis Bass

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 25215 Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month **Medical Examiner** 1040 hrs Artis White Bass August 7, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 715 Vine Street Baltimore If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. **S**ex 7. Age (In yrs. last birthday) **Funeral** Director 2 X F 219-60-7247 1 M Country) Usual Residence of Decedent Oc. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Baltimore MD 1 X Yes 2 No permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important I filem 27 is marked other them. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21201 Stree USA Funeral 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Yes 3 Widowed f Yes, Give Year 1 Yes 2 No specify: 4 Divorced <u>\$</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 17. Father's Name (First, Middle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town State, Zip Code Koaa 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: anc 21. Signature of u 22. Name and Address of Facility Uor Marylaro 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or her Physician Approximate Interval Between Onset and /Medical Alcohol Intoxication Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last signed by the attending physician and be detached for use as the burial - transit To the Hospital or Attending Physician; The law requires that the death certificate be executed Physician/Medical 1,23a,pt.II,27,28a-f per me g906 8-24-10 vt X UNPENDED Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 Yes 2 No 3 Probably 4 ✔ Unknown Hypertensive Atherosclerotic Cardiovascular Disease Completed has been s 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? r this certificate h Yes 2 No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 DOA 1 Yes No After the funeral 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death.

To the Funeral Director: A completely filled in by the fun Natural Pendina 1 Yes 2 X No fd 8-7-10 fd 10:37 unknown Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) (Specify) residence Homicide 715 Vine St. Baltimore, Md. 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) **OCME** O.C.M.E. August 8, 2010 30. Name and address of person who completed a use of death (Item 23a) Assistant Medical Examiner Theodore M. King, Jr., MD. 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month Pays/eg) 20Renistrar's State

Registra

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Vear Physician James Wilbur Barrow Jr. 1:11 A M 2010 August 6, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Forest Hill Harford 2417 Ady Road If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1⊠ M 2□ F 219-42-5272 67 Director Apr. 13, 1943 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10h. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1 ☐ Yes 2 XNo Director Maryland Harford Forest Hill 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 2417 Adv Road 21050 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 ⊠ No Specify: Specify: \$ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Agriculture Farmer 7 Is marked other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle Last) Be ( Pages 1 and 2 should be 1 ment of Health and Mental James Wilbur Barrow Sr. Marjory Lee Enfield ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health and em 27 Is n permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tra Rebecca Barrow / Wife 2417 Ady Road, Forest Hill, MD 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 8-13-10 Towson, Maryland McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, MD 21014 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final ARTERIOSCLEROTIC CARDIOVASCULAR DISERSE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) use as the burial-trar Due to (or as a consequence of): P.O. Box 68760 attending physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Vear 5 ☐ Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has page 2 autopsy Physician: The 1 ☐ Yes 2 MNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner' Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After or Attending 1 W Natural 5 Pending death. 1 ☐Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide the Hospital 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier сопрыеты 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Mybu 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABHYANKAR NORTH AVE 31. Date filed (Month, Day Year) State AUG 12 20 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Day 2010 7 Charles Basil Brookes, Sr. August 10:43 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 86 Northship Road Dunda1k 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 XM 2 □ F Months Days Hours Min 1 1-02-1918 Oh io 213-07-5029 91 Director Usual Residence of Decedent shov 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: I fiem 27 is anarked other than "natural", or items 23a or 28a-f sho important: If item 27 is anarked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 TNo Maryland Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 United States 86 Northship Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14, Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes Give Year or Dates. WWII Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Industrial Engineer Steel Industry 12 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Brookes Elsie E. Hendley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 86 Northship Road Dundalk, Maryland 21222 Mrs. Margaret H. Brookes (wife) Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Parkwood Cemetery 08-11-2010 Baltimore, Maryland 21. Signature of Funeral Service Licer Bulla Ruck Fulleral Home of Dundalk, Inc. Avenue Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a cons quence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death the signed by the Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No Division of Vital Records, 3 Probably 4 Unknown Completed 1 Yes been si should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe certificate 2 No 1 Yes Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes Other: မ 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) this : After this e funeral o 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death. n 24 hours after death.

e Funeral Director: A leted filled in by the fu 1 🗌 Yes 2 🗆 No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tit 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra/s Si

Amend #30 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Marv Matilda Campbell 2010 09:15 A<sup>M</sup> August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1028 Thomas Road <u>Glen Burnie</u> <u>Anne Arundel Co</u>. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, ) 9. Birthplace (State or Foreign 1 □ M 2 🛂 F Year) 914 Months Davs Hours Min 430-14-3419 96 Arkansas Director Jan. Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County filed within 72 hours after death with the Maryland 10c, City, Town or Location 10d. Inside City Limits Director MD 1 ☐ Yes 2 🔀 No Anne Arundel Glen Burnie 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21060 1028 Thomas Road United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify. Specify: White 3 XWidowed 4 □ Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Zora Tibis Toad Hamlin Ida Scott Amy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Stephen D. Campbell, Sr/Grandson 1028 Thomas Road Glen Burnie, MD 21060 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park | 8/12/2010 Glen Burnie, MD Signature of Funeral Service 22. Name and Address of Facility Singleton Funeral & Cremation Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) EMENT Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or Injury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy Pregnant at time of death
Unknown Month Day Year 1 Yes 2 Unknown been signed by the a should be detached Part II. <mark>Other significant conditions</mark> coptributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 2 🗙 No Other: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, To the Funeral Director: After this completed filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a. Certifier 1 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) R17/3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRNP Dolores L. Coleman, 31. Date filed (Month, 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2010 7:46 AM Norma Burgman Connell August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Mary Land 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours 1 □ M 2X□ F 85 Yrs. 524-32-9092 13, Director Usual Residence of Decedent s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Glen Burnie Maryland | Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 302 Andover Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 XNo Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Dress Making / Sales Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Raymond Leroy Burgman, Sr. Helen Marie Clemmons 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amy M. Neary, Daughter 407 Frankle Street Brooklyn, permit. Pages 1 a Department of He Important: If iten 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 08/11/10 Baltimore, Maryland 21. Signature of Funeral Service License Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** o Cardi HOUS /Medical to (or as a consequence of): **Examiner** 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine Cause (Ciscase or injut that initiated events resulting in death) Last and Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months2 1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 -NO 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Madisa Ellip

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

Division of Vital Records, P.O. Box 68760.

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8 Fer FH 6906 8/20/2010 JH State of Maryland / Department of Health and Mental Hygiene 25220 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 8 Physician/ Day Robert Holger 600 A M cline 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death medical Center Baltimore VA Bautimore Social Security Number 6. Sex . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug. 25 9. Birthplace (State or Foreign **Funeral** 1919 1 🔀 M 2 🗆 F Hours 215-05-7999 Country) Maryland **Director** 90 Usual Residence of Decedent 'natural", or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. the Markent Examples 1 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1315 Chesaco Avenue Apt 118 21237 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White If Yes, Give Year or Dates Specify Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Police Officer Public Safety Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ David S. Cline Ruth F. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Smith Daughter 1315 Chesaco Avenue Apt 118; Baltimore, MD 21237 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Lorraine Park 8/14/2010 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 Signature of Funeral Service Licenses 23a. Part . Enter the disease, or con a cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Bilateral Pneumonia Physician/ disease or condition Medical resulting in death) Examiner Bowel 2 weeks Small Obstruction Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to los as a consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 death? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 욘 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MD 8/11/2010 1831358175 Ox, and address of person who completed cause of death (Item 23a) (Type, Print) 10 Nbreenest Baltimore, MD 2120 Tuan 31. Date filed (Month, Day, Year) State Registrar AUG 12.2016

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. d #19aPer FH G906 8/18/2010 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Patricia Carnaggio Physician/ rescer 7 102 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** C Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Birthpic Country) MD **Funeral** 1 M 2 XX 216-36-9523 69 Hours Aug 28, Day 1940 Director Yrs Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director Anne Arundel Glen Burnie MD 1 Yes 2XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Page 1 and 2 should be filed within 72 hours after death with the ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a i Funeral 21061 509 Stanhome Road U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1-XXNever Married 2 Married 1 Yes If Yes, Give 2XXNo Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed)  $\begin{array}{c} \text{Elementary/Seconday (0-12)} \\ 12\text{th} \end{array}$ College (1-4 or 5+) Bindery Company Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Carnaggio, Sr. Mary Hahn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Furmaneck Joan Fuhrmanneck 509 Stanhome Road Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date 1 Systematical 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Greenmount Cemetery 8/13/10 Hampstead, MD 22. Name and Address of Facility Turgee Henss-Seitz Funeral Home 3631 Falls Road Balto, MD 212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner ue to (or as a consequence sician and burial-trans Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 ding physise as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 2 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 <del>□</del>No မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA **To the Funeral Director:** After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medica Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar

State Registrar

		1 - State of Maryland / Dep	partment of Health and N ertificate of Death	Mental Hygier	0010 00000
Physicia		Decedent's Name (First, Middle, Last)  Audrey Odessa Cinquegrani	Timodio of Dodin	2. Date of Death August 9	3. Time of Death
Medic Examin		4a. Facility Name (if not institution, give street and number) Gilchrist	4b. City, Town, or Location of Death		4c. County of Death Baltimore
Funeral Director		5. Social Security Number 6. Sex 1 - M 2 TF 7. Age (In yrs. last birthday, 1 - M 2 TF 81 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth	9. Birthplace (State or Foreign Ma PYTAnd
aryland a-f show fied at	Director	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L  Maryland Baltimore Nottin			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
with the Mi 23a or 28 ust be noti		10e. Street and Number 73 Laurel Path Court	10f. Zip Code 21236		Citizen of What Country?
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 29a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by F	11. Marital Status  1 Never Married 2 Married  3 Nowled 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates.	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 ☒ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
within 72 hour giene. er than "natu , the Medical	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation kind of work done during most of work DO NOT use retired) Inistration Assist	ing	. Kind of Business Industry tate of Maryland
d be filed v Mental Hyg arked oth	To Be	17. Father's Name (First, Middle, Last) Herbert Summers	18. Mother's Nam Odessa F	e (First, Middle, Maide Pierce	en Surname)
nd 2 shoul ealth and I n 27 is ma er trauma		1	ing Address (Street and Number or Rura 5 West Main Street		or Town, State, Zip Code) s, New Jersey 08022
Page 1 arment of Hament of Hament of Hament II iter		TEL Burlar 2 El Cicination 5 El Herrioval nom State	matory or other place)	I .	Location - City or Town, State altimore, Maryland
permit. Departi		21. Signature of Funeral Service Licensee	2. Name and Address of Facility Ruc 050 York Road Tows		Funeral Home, Inc. and 21204
Physician/ Medical Examiner	_	23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,  b.	ter the mode of dying, such as cardiac of of ling abeno		Approximate Interval Between Onset and Death M6HHS
ate be executed ohysician and the burial-transit	dical Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or ilinjury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transition.	Me		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
uires that I n signed b	ed by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		o use contribute to the cause of death? 2   □ No 3   □ Probably 4   \\$\frac{1}{2}\Unknown
The law requate has bee page 2 shou	Complete			24a. Was an autopsy performed 1  Yes 2	
ysician; s certific director,		25. Was case referred to medical examiner?  1  Yes 2  No  Hospital: 1  Inpatient 2  ER/Outpatie	26. Place of Death (Check	me 5 Residence	6 Drother (Specify) Hospice
ending Phy sath. or: After thi he funeral	Certificate: T	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation  28a. Date of injury (Month, Day, Year)  (Month, Day, Year)  28b. Time of injury (Month, Day, Year)		28d. Describe how inj	COL CHICK (Specify)
ital or Atturs after de ral Directureled in by t		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		City or Town, Sta	
the Hosp nin 24 hou the Fune	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge, death only one) 3 Certifying Nurse Practioner: To the best of my knowledge,	stigation, in my opinion, death occurred at	the time, date and pla	ce, and due to the cause(s) and manner state
P With		29b. Signature and title of certifier	29c. License number  10070635	29d. [	Date signed (Month, Day, Year)
101		30. Name and address of person who completed cause of death (Item 23a) (Type, Lawn Patel 670) N Charles		1D 212	02/
State Registra	<b>-</b>	31. Date filed (Month, Day, Year)  32. Digistrar's Signature	are		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			Plea	ase Type or Pri						-		gible.		
		•	For State Registrar	State of ivi	aryiano		artment of F tificate of D		na ivi		Reg. No. 0	10	25223	
	Physicia	n/	1. Decedent's Name (First, Middle		-	-				2. Date of Dea Month	ath Day	Year	3. Time of Death	
	Medic Examin		JOSEPH J.  4a. Facility Name (if not institution		R.		4b. City, Town, or	Location of [		AUGUST	4c. Coun			
, .er			GILCHRIST HOSPICE TOW					ON					MORE	
	Funeral Director		5. Social Security Number 214 22 7408	6. Sex 7. Ago 1 🔀 M 2 🗆 F	e (In yrs. las 83	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours		8. Date of Birt (Month, Day 0 6 / 2 7 /		9. Biri Coi M A	thplace (State or Foreign untry) ARYLAND	
	land show d at	ı	Usual Residence of Decedent  10a. State 10b. County	-	10c. City.	, Town or Loc	cation	<u>'                                    </u>					10d. Inside City Limits	
	death with the Maryland items 23a or 28a-f sho ner must be notified at	Director	MD BAL	TIMORE		DALK							1 ☐ Yes 2¼ No	
	ith the	ral D	10e. Street and Number	7.57			10f. Zip Code				10g. Citizen of	What Co	ountry?	
	eath w	Funeral	7518 SCHOOL  11. Marital Status	12. Was Decedent B	ver in U.S.		Vas Decedent of Hi	2122 spanic Origin	? (Spec	ify Yes or No-	USA 14. Ra	ice - Ame	rican Indian,	
	filed within 72 hours after death with the Maryland the Hygiene. At Hygiene. At the Hygiene than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at	by		1 ☐ Never Married 2 ☐ Married   15€ Yes 2 ☐ No			Yes, specify Cuba		-иепо н	ican, etc.)		Black, White, etc. Specify: WHITE		
-c_	72 hou n "natu fedical	Completed		nt's Education est grade completed)		(Give k	ent's Usual Occupa	ation luring most of	f workin	g	16b. Ki <i>n</i> d of I	Busi <i>n</i> ess	Industry	
	within giene. <b>er tha</b>		Elementary/Seconday (0-12)	College (1-4 or 5	+)		O NOT use retired) SPATCHER	₹				GE		
land	be filed with ental Hygier ked other t ic event, th	To Be	17. Father's Name (First, Middle, I	Last) DOLAN SR.				18. Mother's NAOM		(First, Middle, I	Maiden Surnan			
Mary	should be fill and Mental is marked raumatic ev		19a. Informant's Name/Relations	g Address (Street a	and Number o	or Rural	Route Number	; City or Town,	State, Zip					
esî Os	and 2 Health Sm 27 Sher tr		TIMOTHY P. D  20a. Method of Disposition	OLAN/SON	20h Die		HILBOR	N ROA			•			
E C	Page 1 nent of int: If it		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 🔀 Other (S		ce	metery, crem	natory or other plac  N CEM.			/10	20c. Location	•		
saitimore,	permit. Page 1 a Department of I Important: If its any injury or ot		21. Signature of Funeral Service I		1 0111	22.	Name and Addres	s of Facility	CVAC	CH/ROS	EDALE	FUN	ERAL HOME	
	TT = # 0	_	23a. Part 1, Enter the disease, of	complications that caused	the death.					E BALT		, MD	21237 Approximate	
P	h sician/		shock, or heart failure. List of Immediate Cause (Final disease or condition	only one cause on each line		dial	in for	ction	7				Interval Between Onset and Death	
	Medical Examiner		resulting in death)	Due to (or es a	conseque	ence of):	in for	deres	ase				years	
	, #	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a	conseque	ence of):	10.0	014-1	- (				_ GIROVI J	
	xecute n and al-trans	Exan	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a	conseque	ence of):						-		
3	are be e	dical		d										
00/00	nding p	In/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. D	ate of del	iverv	
. DOX	to the rospiral or Attending Priystain: The law requires that the deam certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live Birth 4 Pregnant at 9 Unknown			Ectopic pregnancy Other (specify)	у				onth	Day Year	
, r	es tnat t signed b I be deta	ρ	Part II. Other significant condition	ons contributing to death be	ut not resul	lting in the ur	nderlying cause giv	en in Part I.		1.4			the cause of death?	
ecords,	s been s	Completed								24a. Was a	n 24b.	Were aut	topsy findings available	
ב ב	cate ha	Com	=							autop: perfor 1  Yes	sy med? 2 A No	death?	completion of cause of	
ב ב	ysician s certifi director	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:	ent 2 🗍 F	R/Outpatient	Othe	ace of Death (		only one) ne 5 🗆 Reside	ance 6 Mott	ner (Speci	100 h 230110	
5	Affer thi		27. Manner of Death 1 Natural 5 □ Pendir	28a. Date of injur	у 2	28b. Time of injury	28c. Injury work	at ?	28	3d. Describe ho			197 10757709	
	Attence er death ector: / by the l	Certificate:	2 Accident Investig 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of Inju		ne, farm, stre		Yes 2□ No				oer or Rur	ral Route Number,	
2 :	piral or ours afte eral Dir filled in		000 Continue 4 20	building, etc				data dla-	Į.	City or Towr				
	to the nospital of Attending Fripsician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	Medical	(Check 2 Medical E only one) 3 Certifying	Physician: To the best of examiner: On the basis of ex Nurse Practioner: To the basis of the bas	amination a	and/or investi	gation, in my opinio	n, death occur	rred at th	ne time, date ar	nd place, and du	ue to the c	cause(s) and manner stated.	
	with con		29b. Signature and title of certifier	Mus			29c. License	number 83	03	2	29d. Date signe	ed (Month	9 2010	
1			30. Name and address of person	who completed cause of de	eath (Item 2	23a) (Type, Pr	int)	Chris	Rle	3 ( 1	- 1702	500	u mo	
	State		31. Date filed (Month, Day, Year)	32. Re Astra	Signatu	re	San N. D	V - W		2 3-1	7 - 0			
	Registra		AUG I	S AND AMERICA	المسألامة	15. 19	arre							

State of Maryland / Department of Health and Mental Hygien 2 1 1 For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ <sup>D</sup>7<sup>y</sup>, 2010 August 2:15 William James Daehnke Ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore City Joseph Richey Hospice 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Sex 1 M 2 □ F Days Sept. 7, 1923 Director Yrs Maryland 215-18-5849 86 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1924 |21230 United States Breitwert Ave. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 24 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exal If Yes. Give Specify: White 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 9th N/A Sheet Metal Worker Manufacturing Firm Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Margaret Ann Galway William Rudolph Daehnke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 McKenna St. Dover, NH 03820 <u>Joyce Lobell Galway/Daughter</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Meadowridge Mem.Park Aug. 10,2010 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses AMBROSE AFUNERAL HOME OF LANSDOWNE SLEWIN 2719 Hammonds Ferry RD. Lansdowne Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ conocs Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): executed attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Year Month Day 1 Yes 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an s certificate has lirector, page 2 s autopsy performe 2 No 1 Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital on within 24 hours aff To the Funeral Discompleted filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number menino, ERNP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Camille Menino Eutaw Street Battimore MD 21201 North 31. Date filed (Month, Day, Year) AUG 12 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- For State of Maryland / Dep Registrar Ce	artment of Health and rtificate of Death	Mental Hygieno Reg. No	C
0	Physici /Medic		1. Decedent's Name (First, Middle, Last)	olette	2. Date of Death AMONTH P	Year 05.13 A M
	Examir	ier	4a. Facility Name (If not institution, give street and number)  The Johns Hopkins Hospital	4b. City, Town, or Location of Dea	•	c. County of Death
	Funeral Director		5. Social Security Number 267–40−2885 6. Sex 1 M 2 X F 80 Yrs.	If Under 1 Year If Under 24 Hr Months Days Hours Mir		9. Birthplace (State or Foreign Country) Florida
	Maryland -f show ed at	tor	Usual Residence of Decedent	ocation edra Beach		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	ith the l	Director	10e. Street and Number	10f. Zip-Code		itizen of What Country?
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral		32082  Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue  1 ☐ Yes 2X No Specify:		ed States of America  14. Race - American Indian, Black, White, etc.  Specity: White
Maryland 21215-0036	l within 72 houiene. iene. r than "natura the Medical E	Completed		edent's Usual Occupation kind of work done during most of w DO NOT use retired) Cail Buyer	vorking	Kind of Business/Industry
/land 2	uld be filed Mental Hygarked other itic event, t	To Be C	17. Father's Name (First, Middle, Last) Milo Wellington Bennett	18. Mother's N	lame (First, Middle, Maide Preston	
	1 and lealth am 27 ther to			ing Address (Street and Number or lost Conway Ave., Ta	ikoma Park. N	
altimore,	Page Tent o		1   Burial 2   Cremation 3X Removal from State   Cemetery, cree   Calculus   Cemetery 08/	14/10 Jack	ksonville, FL.	
Ba	permit. Departn Importa any inju		23a. Part 1. Enter the disease, or complications that caused the death. Do not en	В	_	-Seitz Funeral Home cyland 21211 Approximate
	Physician /Medical		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a  Die to (or as a consequence of):	•		Interval Between Onset and Death
	cate be executed by hysician and the burial-transit the burial-transit	dical Examiner	Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b.     Tacheomalac	1a	·	
O. Box 68	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Mec		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
ds, P.O.	uires that t signed by ild be deta	ò	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		use contribute to the cause of death?
		Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2  No
r Vita	rsician: s certifica director,	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No Hospital: 1 Ninpatient 2 ☐ ER/Outpatie	Other	eath (Check only one)  Home 5 Residence	6 ☐ Other (Specify)
ion of	nding Phy ath. r. After this te funeral	ertification: 1	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	of 26c. Injury at Work?  M _1 \ Yes 2 \ No	28d. Describe how inju	ury occurred
DIVISION	To the Hospital or Attending Physician: within 24 hours after death and the Funeral Director. After this certifica completely filled in by the funeral director,	O	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, st building, etc. (Specify)		City or Town, State	
	e Hospi 24 hou e Funer letely fil	edical	29a. Certifier (check only one)  1 **Certifying Physician: To the best of my knowledge, deal check only one)  1 **Medical Examinary On the basis of examination and/or in and manner stated.	n occurred at the time, date and place avestigation, in my opinion, death oc	ce, and due to the cause(securred at the time, date an	s) and manner as stated.  nd place, and due to the cause(s)
	Vithin To the comp	Me	29b. Signature and title of certifier	29c. License number	29d. Da	ate signed (Month, Day, Year)
	10		30. Name and address of person who completed cause of death (Item 23a) (Type	RES- DOO	<u> </u>	gust 1,2010
	1		# SPEE MON MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature		) North Wolfe S	St, Baltimore, MD, 21287
	Sta Registr	re l	AUG 12 2010			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ KATHERINE Month RUIH DIXON :25 AM Medical OI 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington If Under 1 Year If Under 24 Hr 5. Social Security Number Funeral 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign Hours February 6, 1919 213-09-8791 Mary Land Director 91 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Pennsylvania Fulton Warfordsburg 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 812 Church road 17267 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes, Give 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ William Т. Carper Margaret Steinbach Health and Internation 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William E. Dixon Sr. (Son) 812 Church Road, Warfordsburg, Pennsylvania 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Cemetery permit. Page 1 a Department of H Important: If ite any injury or ot 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 08-13-10 Brooklyn Park, Maryland 21. Signature of Fur ral Service Lices 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 130 E. Fort Avenue, Baltimore, Maryland 21230 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between mmediate Cause (Final Onset and D, ath Physician disease or condition resulting in death) Medical ue to fr as a consequence of Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 f yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes No 3 Probably 4 Unknown Completed After this certificate has been funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medica æ 26. Place of Death (Check only one) examiner? Hospital Other: 2 X No ျှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural in 24 hours area the Funeral Director: After the filled in by the fu work Accident 1 🗀 Yes 2 🗆 No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. The design of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one 29b. Signature and title of 29d. Date signed (Month, Day, Year) 2010

Registrar
DHMH 17 Rev 7/2009

State

Northern

5 20

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 25227 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Joan M. Entwistle 2010 August 12:35 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist Center 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Funeral 8 Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🛛 F Months Days 147-54-2521 54 1170371955 Director ETMER. NJ Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director PA York Dallastown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 231 S. Franklin Street 17313 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 💢 No If Yes, Give 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) +5 Elementary/Seconday (0-12) should be filed within and Mental Hygiene. Visiting Nurses Physical Therapist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Doris M. Kennedy John H. Datz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau S. Franklin Street, Dallastown, PA 17313 Dean E. Entwistle/ husband 231 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date le ffner funeral (crematory or other place)
Leffner funeral (chapel & Crematory 08/13/2010) 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) York, PA 22. Name and Address of Facility Towson, 21. Signature of Funeral Service Licenses 21204 Inc. 1050 York Rd. MD ame Ruck Towson Funeral Home, 23a. Part 1. Enter 1 e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ garglis hemos havir disease or condition 1 2016 Medical resulting in death) Examiner ran 60 cy to monters Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Physician: The law requires that the death certificate be executed burial-transit Lympho 6/25hc Acute Due to (or as a consequence of): resulting in death) Last physician the burial Physician/Medical attending p for use as t IF FEMALE: 23b. Was decedent pregnant 23d, Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown q 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page performed? 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes 2° No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) NOSD W this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Hospital or Attending Natural > 5 Pending s after death.

I Director: Aft
d in by the fur 2 Accident
3 Suicide
4 Homicide М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a Funeral D Medical Descritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner On the basic of examination and/or investigations and the state of examination and/or investigations. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Within 2 only one) 29b. Signature d title of certifier

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Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

UANLIES

32. Redistrar's Signature

Mn

State Registrar 6201

N-

Chences

10 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AMonth Year CECIL ELWOOD FUNKHOUSER 1000 AM Medical 010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SHADY GROVE ADVENT HOSPITAL ROCKVILLE MONTGOMERY 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye DEC. 21, 1 If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 1 🕱 M 2 🗆 F Months Hours Yrs **Director** 231-98-8293 1957 VIRĞINIA Usual Residence of Decedent 28a-f show aith and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho r traumatic event, the Medical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No PRINCE WILLIAM MANASSAS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6339 EMBER COURT 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: WHITE Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) AUTO TECH AUTOMOTIVE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ CALVIN ELLIOTT FUNKHOUSER SR LUCY ANN WRIGHT Page 1 and 2 should ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other the once. 63<u>39 EMBER COURT MANASSAS, V</u>A ROBERTA FUNKHOUSER-WIFE 20112 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 08/12/2010 4 ☐ Donation 5 ☐ Other (Specify) DUMFRIES CEMETERY DUMFRIES, VA CUNNINGHAM-MOUNTCASTLE FUNERAL HOME INC. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ Myo cardia Acute disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, it any leach get a time districts cause. Enter Underlying Physician/Medical Examiner Die to (in as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi and Due to (or as a consequence of): ate has been signed by the attending physician page 2 should be detached for use as the burial Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops, performed within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 1 Yes 2 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2. No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending work? 1 🗌 Yes 2 🗌 No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature an title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 9901 Car MD 20450 Tama medical 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 3:57 AM ZELMA August FISHER 2010 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital Baltimore Baltimore N/A 0, 5. Social Security Numb If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country)
 MD Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🗓 F Months Hours 0676671920 Director 90 MD 109-14-2659 Usual Residence of Decedent artment of Health and Mental Hygiene.
ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show
injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director 1

Yes 2 □ No N/A BALTIMORE Fisher 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3615 FORDS LANE, APT. 713 21215 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify. WHITE Specify: Completed 3 Widowed 4 Divorced Zell. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 SALESPERSON CLOTHING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic e FISHER SARAH MAGED 大いないと 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PLEASANT RIDGE DR., #301, OWINGS MILLS, MD GILDA KRAMER/SISTER 20a. Method of Disposition ARIM NETAN (Name of ZUK 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) AMUNO CEMETERY 08/12/2010 BALTIMORE, MD Signature of Funeral Service Licente 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Ph, sician/ fartial small obstruction disease or condition day Medical resulting in death) Due to (or as a consequence of) **Examiner** Preumonia 10 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 10 days physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending phys IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death the a 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by · recent icate has been siç 7, page 2 should b Ischemic 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown PSVT 24b. Were autopsy findings available prior to completion of cause of death? Hypertension 24a, Was an autopsy performed? Yes 2 N certificate 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ည 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? After 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident 1 Yes 2 No Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License numbe MBBS RES - 000 August 10 2010 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who 6V Hospital of Baltimore MBBS Sinau 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10a-f Per INF G911 1/24/2011 Jh State of Maryland 7 Department of Health and Mental Hygiene For State Registrar 25230 Certificate of Death 1. Deceldent's Name (First, Middle, Last) 2 Date of Death Physician/ Conth Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE 2800 STONE CLIFF DRIVE, #306 BALTIMORE 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 X M 2 □ F Days Min. 0370671931 Director MD 215-28-4559 79 Usual Residence of Decedent 23a or 28a-f show Palm Beach 10a. State City, Town or Location
WEST Palm 10d. Inside City Limits Examiner must be notified at Director Beach XX Yes 2 No BALTIMORE MD BALTIMORE 8666 8666 10f. Zip Code 10g. Citizen of What Country? Falcon Green Drive Funeral 33412 USA items 72 hours after death Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ⚠ No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 X Married "natural", or 21215-0036 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced WHITE Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than " Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha 12 COMPANY OWNER AMERICAN LUMBER Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ FARBMAN BENESCH DEWEY RENA and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2800 STONE CLIFF DRIVE, #306, PAULA FARBMAN / WIFE BALTIMORE, MD 21209 other Baltimore, Department of Heal 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, injury or Begation 5 Other (Specify) SHALOM MEM. PARK: 08/11/2010 REISTERSTOWN, MD Signature of Funeral Service Licens 22. Name and Address of Facility SOL LEVINSON & BROS., INC. any REISTERSTOWN ROAD, PIKESVILLE, MD 21208 8900 Part 1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MIC disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear Pregnant at time of death been signed by the sahould be detached 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy 1 Yes 2 No certificate Yes Hospital or Attending Physician: 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) funeral director, æ examiner? Hospital Other: 2 No 1 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury 5 Pending ours after death.

neral Director: Aff
filled in by the ful 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital of within 24 hours at To the Funeral D completed filled is Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c, License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10V 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AUGUST 10, \_2010<sup>Year</sup> 1:56 P M KATHLEEN GORDY FRY Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HARFORD UPPER CHESAPEAKE MEDICAL CENTER BEL AIR 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day Y Delaware Hours Year 1933 **Director** 220-32-1835 Usual Residence of Decedent or 28a-f show 12 should be filed within 72 hours after death with the Maryland that and Mental Hygiene. 25 This marked outher than "natural", or items 23a or 28a-f sho 27 is marked outher than "natural", or items 23a or 28a-f sho retarmatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No Maryland Harford Bel Air 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21015 1310-H Scottsdale Drive 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Public Schools Instructional Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Paul Clayton Gordy Anne (unk) Grier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Lloyd C. Fry / Husband 1310-H Scottsdale Drive, Bel Air, Maryland 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State Bel Air, Maryland 8/14/2010 Bel Air Memorial Gdn 4 ☐ Donation 5 ☐ Other (Specify) McComas Funeral Home, P.A. Fungal Service Lipensee 22. Name and Address of Facility 1317 Cokesbury Road, Abingdon, Maryland, 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Death Immediate Cause (Final ARTERLUSCIERO11C Physician/ DIOVASCULAR disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSIDN 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? DI ABETES 24a. Was an autops\ 1 🗌 Yes 2 🗌 No Yes 2 14 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \( \sum \) Yes 2 \( \sum \) No Hospital: Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 5 Pending 2 Accident 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

Division of Vital Records, P.O. Box 68760 within 24 hours after deau.

To the Funeral Director: After this c

12 State

30. Name and address of person who cor

Registrar

31. Date filed (Month, Day, Year

29b. Signature and title of certifie

29a. Certifier

(Check

leted cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

AUGUSI

2010

MD 21014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ PM 1:35 Nellie Virainia Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8. Date of Birth 7. Age (In vrs. last birthday) Birthplace (State or Foreign **Funeral** 1 □ M 2 🎗 F Months Month, Day, **Director** Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a State 10b. County other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 🔀 Yes 2 🗌 No MOC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. ξ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. Completed 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NQT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ence Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Dopation 5 Other (Specify) 3/2010 e of Funeral Service Licensee 22. Name and Address of Facility
JOSEPH L. RUSS
2222 W. NOTTA unera enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1 Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Lancer Physician/ Breast disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease Or finjury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown within 24 hours after death.

To the Funeral Director, After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 🗌 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) USKajapahne M.D D0057465 8/11/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 Smith AV- 5-203 - Baitmore, MD. 21209

State Registrar

N.S. Rajapakse, M.D

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	State of M	aryland		ırtmer <i>tificat</i>			and M		giene. Reg. No.		25233
Phy	ysicia	n/	1. Decedent's Name (First, Middle, Last Lorraine Alex	xandria	Co	rmuth					2. Date of Dea Month	th Day	/ Year	3. Time of Death
	Medic camin		4a. Facility Name (if not institution, give s		Ge	Imutii	4b. City, Town, or Location of Death			08	10 4c.	2010 County of Deat		
one "			Tate Hospice Hous				ICI I . I .		inthic					Arunde1
	neral ector		5. Social Security Number 6. Security Number 217–26–2037	х м 2 <b>Ж</b> F	e (In yrs. las 79	st birthday) Yrs.	If Unde Months	Days	If Under I Hours	24 Hrs. Min.	8. Date of Birth (Month, Day 12/02/	Yea <i>r)</i> 1930	9. Birt Coa	thplace (State or Foreign untry) PA
and	i at	ō	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Loc	ation							10d. Inside City Limits
e Maryl	notified	Funeral Director	MD Anne A:	rundel			140¢ 70		Glen Burnie				1 ☐ Yes 2 🛣 No	
with the	ed tsi	eral [	10e. Street and Number 615 Mayo Road				10f. Zip	Code	210	61		10g, Citi	zen of What Co U	U.S.A.
<b>DalkilmOre, IMary/iand ZIZI3-UU30</b> permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Innortant: If item 27 is marked other than "natural", or items 28a or 28a-f show	miner m	by Fun		12. Was Decedent E Armed Forces? 1 \(\sum \) Yes 2 \(\overline{\text{X}}\)		If	Yes, spec	cify Cubar	n, Mexican	gin? (Spe , Puerto I	cify Yes or No- Rican, etc.)		14. Race - Ame Black, White	
Z13-UUSO in 72 hours after e. nan "natural", o	cal Exa		3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates.		16a. Deced			Specify:				Specify:	White
<b>6 7</b> in 72 h in 72 h in 72 h	e Medi	Completed	(Specify only highest grade Elementary/Seconday (0-12)		5+)	(Give k	ind of wo NOT use	rk done d retired)	luring most	st of working		TOD. KI	Kind of Business Industry	
a kill led with Hygien	ent, th	BeC	12 17. Father's Name (First, Middle, Last)				ŀ	lomen	naker 18. Mothe	er's Name	(First, Middle, I	Maiden S		Home
yland Jid be filed Mental Hy	atic ev	유	Unknown Dr	ess1er					U	nkno	wn			
Mar 2 shou Ith and 27 is m	traum		19a. Informant's Name/Relationship (Type		on	19b. Mailin <b>54</b> 2	_	Street a			Route Number, <b>Pasaden</b>	-		,
1 and 1 Heal	other		Mr. Joseph J. Ge			ace of Dispos metery, crem	sition (Nar	ne of			ate		cation - City or	
Daltimor  Dermit. Page 1  Department of  moortant: If i	jury or		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			dowric	lge M	em P	ark		6/2010		-	Maryland
par permit Depar	any in once.		21. Signature of Funeral Service License	e	Moss				s of Facility Funer	_	2nd Av Cremat			en Burnie, Mi es. P.A.
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on	lications that caused e cause on each line	the death.									Approximate Interval Between
Physic Med	ian, dical		Immediate Cause (Final disease or condition resulting in death)	a. hefe	406	e Pri	non	y Pe	itar	al C	Percu-Di	ma		Onset and Death
Exam	niner	_	Sequentially list conditions,	b.	a conseque	siice oi).								
pe	nsit	Examiner	cause. Enter Underlying Cause (Disease or linjury	Due to or as:	a conseque	ence of j:								
ate be executed ohysician and	the burial-transit	that initiated events resulting in death) Last C. Due to (or as a consequence of):												
cate be	the bu	edical		d								_		
A 00 A n certific	r use as	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live Birth	of pregnan 2  Fetal	cy death 3	Ectopic	pregnanc	у				23d. Date of del	·
he death of the atter	ched fo	by Physician/M	1 Ves 2 No 9 Unknown	4  Pregnant a 9  Unknown	at time of de	eath 5	Other (s	pecify)					Month	Day Year
DIVISION OF VICE TACCOLDS, F.O. DOX OO TO the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p	be deta	by P	Part II. Other significant conditions co	ntributing to death b	out not resu	Iting in the u	nderlying	cause <b>g</b> iv	en in Part I					the cause of death?
e law requires	should	leted									24a. Was a		24b. Were aut	topsy findings available
The law ate has	page 2	Completed									autop: perfor 1  Yes		death?	completion of cause of
VICAL ysician: s certific	rector,	Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:				Otho	ace of Deat					16
OIV Tig Phys	neral di	te: To	27. Manner of Death  1. ■ Natural 5 □ Pending	1 ∐ Inpation  28a. Date of inju  (Month, Day	iry 2	R/Outpatien 28b. Time of injury		OA   28c. Injury work	4 ⊔ Nu ≀at		me 5 L Residence			ity) HOSpice
DIVISION al or Attendin s after death.	y the fu	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	ury - At hon	ne, farm, stre	M et, factor	1 🗆 '	Yes 2 🗆	-	28f. Location (Si	treet and	Number or Rui	ral Route Number,
ital or A	led in b		4 ☐ Homicide determined	buildin <b>g</b> , etc	c. (Specify)						City or Town	n, State)		
FEMALE:   23b. Was decedent pregnant in the past 12 months?									the time, date ar	nd place,	and due to the	cause(s) and manner stated.		
29b. Signature and title of certifier  29c. License number  4 (77 44)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  5 Au A 5 CHUALT 203 Horn Follows  State  Begistrary  31. Date filed (Month, Day Year)  32. Registrary's Signature								2	29d. Date	e signed (Month	n, Day, Year)			
			30. Name and address of person who co	ompleted cause of d	leath (Item 1	23a) (Tvne D	rint)	H1	77 7	4			F/	10/10
			Dr DAVID S	coup	172		03	Hos	nital	285	, 61e	en .	BUINE	Jud 2106/
Be	Stat		31. Date filed (Month, Day, Year) AUG 122	32. Registra	ar's Signatu	ire .	back	13						

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 25234 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month  $\mathbf{A}^{\mathsf{M}}$ **Physician** July 27 2010 8:35 Elsie Ruth Gavitt /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Sanctuary At Holy Cross Burtonsville **Burtonsville**  Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 □ M 2 😿 F 02/27/1925 Kentucky 85 Director 407-22-6725 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Maryland 10a. State 10b. County Show item 27 is marked other then "natural", or items 23a or 28e-f shov other traumetic event, the Medical Examinal must be notified al 1 Yes 2 □ No **Burtonsville** Director Montgomery MD 10g. Citizen of What Country? the 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with to nent of Health and Mental Hygiene. Int: If item 27 is marked other then "natural", or Items 23a or it U.S.A. 20866 3415 Greencastle Road Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 **X**Yes 2 □ No If Yes, Give Year or Dates: 11. Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🛣 No Specify: Baltimore, Maryland 21215-0036 by 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Customer 15. Decedent's Education (Specify only highest grade completed) Customer Service College (1-4or 5+) Elementary/Secondary (0-12) Banking Representative 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Gertie Lee Ernest Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) Ellicott City, MD 21043 8414 Church Lane Drive Diane Zink / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1 Department of H Importent: If ite any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 08/25/2010 | Arlington Virginia Arlington National 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mountcastle Funeral Home 21. Signature 4143 Dale Blvd., Dale City, VA 22193 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for an a consequence of Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical use as the IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b Was decedent pregnant 3 Ectopic pregnancy Day Month detached for in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s 1 ☐ Yes 2 ☐ No 1 ☐ Yes the Hospital or Attending Physicien: 26. Place of Death (Check only one, 25. Was case referred to medical examiner? director, Be Hospital: 1 Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 25 3 DOA 2 ER/Outpatient 2 1 Tes this 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: After Injury 1 Natural 2 Accident 5 Pending 1 Tes 2 No investigation death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 124 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 DOD52861 of person who completed cause of death (Item 23a) (Type, Print) 0 AVENUE SILVER SPRING MD20902 EORGIA 01 32. Registrar's Signature 31. Date filed (Month, Day, Year) AUG 12 2010 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 12:15PM DUTISOR MOMOUS M Medical 4a. Facility Name (if not institution, give street and number City, Town, or Location of Death 4c. County of Death Examiner 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Hours Min. May 30° 218-46-0930 Mary Land Director Usual Residence of Decedent 28a-f show 10a. State 10d. Inside City Limits 10c. City, Town or Location Examiner must be notified at Director 1 ☐ Yes 2 🏻 No MD Worchester Ocean City 10f. Zip Code 10e Street and Number ö 10g. Citizen of What Country? Funeral items 23a 10138 Golf Course Rd., Apt. United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces? Black, White, etc. 9 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 X Yes 2 ☐ No Specify: If Yes, Give Year or Dates White "natural", 3 Widowed 4 Divorced 1970 Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Person Hotels Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Garrison, Sr. Rose M. Wolf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary R. Garrison - Sister 13166 Ridge Rd., Stewartstown, PA 17363 . Method of Disposition 20b. Place of Disposition (Name of Medidowratogeothermorial 20c. Location - City or Town, State Cremation 3 Removal from State 8-13-2010 Park Elkridge, MD 5 Other (Specify) Ambrose Funeral Home, Inc. 22. Name and Address of Facility 1328 Sulphur Spring Rd., Arbutus, MD 21227 art 1. Enter the disease, or complications that caused Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. rval Retween Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 X No 1 Yes 2 No 24 hours after death.

Funeral Director: After this certific eted filled in by the funeral director, Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 X No Other: 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 No 1 Yes Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 deficial Examinet. On the basis of examination and/or investigation, in my opinion, death paccurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practice er: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the I within 2. 29b. Sig ed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 10 2010 AUGUST IDA C. GALLOWAY /Medical 4c. County of Death Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE ST. AGNES If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 X Months Director 212-48-1759 63 JUL 11 1947 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinant transition at Director 1 X Yes 2 □ No MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2719 W. BELVEDERE AVENUE Funeral 21215 U.S.A. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 □Yes 2XNo Specify: Specify: BLACK ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ACCT. ASSISTANT H<sub>2</sub>O DEPT 7th grade permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HENRY C. WILSON IDA McKINNEY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Galloway 2719 W. BELVEDERE AVE. BALTIMORE, MD., 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Kurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 08-17-10 OWINGS MILLS, MARYLAND 21. Signature of Fun and Service license 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVE. BALTIMORE, MD., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Approximate Interval Between Onset and Death **Physician** DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): certificate be executed physician a the burial-Due to (or as a consequence of): Be Completed by Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 menths?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy ō Month Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? METASTATIC LESIONS TO LIVER AND BONE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No ☐Yes 2☐No i∐Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Records, of Vital

Division Hospital or Attending within 24 hours after deatl To the Funeral Director:

Registrar

Medical

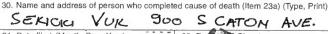
SEKICICI 31. Date filed (Month, Day, Year)

29a. Certifier

(Check only one)

29b. Signature and title of certifier

VUK





MD



1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

P25487

29d. Date signed (Month, Day, Year)

10

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 80<sup>M</sup> 08 ŽÖ10 5:55 DМ Nancy A. Grimmel-Lawrence Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore <u>Good Samaritan Nursing Center</u> If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral Days 1 M 2 X F Hours Min. 0472571950 MD Director 218-50-5952 60 ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🗓 No Fallston Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21047 900 Dellwood Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 💢 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: "natural", Completed 3 X Widowed 4 □ Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Healthcare Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Α. Prestianni Grimmel Nancy W. George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9305 Sandra Park Road, Perry Hall, MD 21128 Anthony Battaglia, Cousin 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 08/11/2010 Towson, Maryland 4 Donation 5 Other (Specify) Hilltop Svc. Corp. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 5305 Harford Road Elexand Baltimore, MD 21214 Ruck, Leonard J. 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician/ rogressive disease or condition Medical resulting in death) Due to (or as a correquence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death be detached for use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year Pregnant at time of death 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed within 24 hours after death.

To the Funeral Director. After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 No 2 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 ANO Other: 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work 1 Yes 2 🗆 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number

0 58570 29b. Signature and title of certifier ena Type, Print) Soul lock Raven Blud Beltimore 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

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Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Patricia Isabelle Guerieri 9:15 P M August 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Baltimore Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Month, Day, Yea March 26 1 🗌 M 2 💢 F Hours 215-14-8743 87 **Director** Usual Residence of Decedent 28a-f show 10a. State "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director Md. Baltimore 1 Yes 2 No Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9440 Seven Courts Drive 21236 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: White Completed 3 X Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dominic J. O'Brien, Sr. Elizabeth Walsh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>s</u> and 2 s Health s Sharon-ann Guerieri/ Daughter 9440 Seven Courts Dr. Nottingham, Md. 21236 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🛛 Other (Specifyntombment Dulaney Valley Mem. 8-14-10 Timonium, Md. 21. Signature of Funer Service Vicense 22. Name and Addr Ruckacill Fowson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 23a. Part 1. Enter the Visease or complic rior is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cruse on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ complications reaves Medical resulting in death) Due to fir as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Trial to (or as a consequence of): and -transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death should be detached 1 ☐ Yes ∠ ⊭ 9 ☐ Unknown 9 | Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hemorhagic Stroke, Atria Fibrilla tilh 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has performe this certificate 2 🗌 No 1 Tyes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No 1 🗌 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ★ Other (Specify) Hospice ျ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1. Natural 5 Pending 1 Tes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in the opinion, occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 00070635

Box 68760

Records,

Division of Vital

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Charles

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day CTA Physician/ Year B GEORGE 02:12 AM BAMES Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Glen Burnie Anne Arundel Baltimore-Washington Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7, Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours December 3. 1950 Pennsylvania Director 59 171-42-4124 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No Pasadena Maryland Anne Arundel 10f. Zip Code ò 10e. Street and Number 10g. Citizen of What Country? U.S.A. 21122 items 23a Funeral 7860 Tick Neck Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ò 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: 3 🗌 Widowed 4 🗌 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important. If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Police Officer 0 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) James George Evelyn Mataba 19a. Informant's Name/Relationship (Type, Print)
To App (Corpe (WITE) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jo Ann George 7860 Tick Neck Road, Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 A Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) August 12, 2010 Elkridge, Maryland Meadowridge Mem. Park 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 21. Signature of Funeral Service License 3204 Mountain Road, Pasadena, Maryland 21122 23a. Par . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sor ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Impordiate Cause (Final see ase or condition resulting in death) Physician/ DRONATE HEART Medical Due to (or as a consequence of): Examiner 2415. Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Exami To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 2 No 1 Tes 25. Was case referred to medica 26. Place of Death (Check only one) B B examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 잍 1 🗌 Inpatient 2 💢 ER/Outpatient 3 🗌 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of Certificate: 1 Natural 5 Pending 1 Tyes 2 🗆 No hours after death Accident Investigation within 24 hours after dex To the Funeral Director completed filled in by th 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ignature and title of certifie

Registrar

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TODOMO EVERSI e filed (Month, Day, Year) AUG 12 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0054739

7845 OAKWOOD Rd Ste204 Glen Burnie, MD. 21061

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b&c. Per FH C906 8/19/2010 JH amend #20b&c. Per FH C906 8/19/2010 JH and Mental Hygiene 25240 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Catherine Henry Phyllis 22:24 09, 2010 August 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore Greater Baltimore Medical Center Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Hours 1 □ M 2 💢 F Yrs NC 246-78-6995 10 11 47 62 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 X No MD Carroll Eldersburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21784 5725 Banjo Drive 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 □ Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes 🛂 No Specify: Specify: Black 3 ☐ Widowed 4 ▼ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Rehabilitation Elementary/Secondary (0-12) College (1-4or 5+) Services Client Tech. Support 12th grade 2yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Catherine Miller Robert Barnes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 5725 Banjo Drive, Eldersburg, Md 21784 Karen Carey-Daughter 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Lake View Meni-Park Sykesville,MD 1 □ Burial 2 □ Cremation 3 □ Removal from State 8/16/2010 Timonium, 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley 21. Signature of Funeral Service Licens March F/H West Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a Widely retastatic endometrial adenocarcinera 18 months Due to (or as a consequence of): Sequentially list conditions, if any least 11 minutes cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Bilateral gangrenous necrosis of the lower extremities 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Bilateral occlusive thrombophlebitis of the lower autopsy performed? 2□No 1XYes 2 No Yes extremities. Disseminated intravascular coagulation 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day Year)

Physician /Medical **Examiner** The law requires that the death certificate be executed attending physician for use as the buria Division or Vital Records, P.O. Box 68760

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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**Funeral** 

Director

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

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permit. Pages 1 and 2 & Department of Health ar Important: If item 27 is any injury or other trau

Baltimore, Maryland 21215-0036

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death with the Maryland

Examiner Physician/Medical ģ Completed Be Certification: To

certificate I

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After

within 24 hours after death To the Funeral Director:

director.

filled in by the funeral

completely

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4 ☐ Homicide

Attending Physician:

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the Hospital

5 Pending investigation 1 Natural 2 Accident 3∏ Suicide

6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier Devel

D28885

08 0 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Howard L. Siegel, M.D. - GBMC 6701 N Charles Street; Baltimore MD 21204 31. Date filed (Month,-Day,-Year) - ----

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First Middle | ast) 2 Date of Death Physician/ Charles August Hartman ักั่ 08 2010 6:26 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Carroll Dove House Westminster 8. Date of Birth (Month, Day, Year) 05/07/1977 Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1**XX**M 2 □ F Days Min. 33 Director 213-90-6095 Usual Residence of Decedent or 28a-f shove notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 X No MD Brooklyn Park Anne Arundel 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 5319 Patrick Henry Drive 21225 U.S.A. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 2 XNo 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: "natural", Completed 3 Widowed 4 Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natum any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Anne Arundel County Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Technician Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Richard Hartman Suzanne Mary Schanken 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. April L. Hartman / wife 5319 Patrick Henry Drive, Brooklyn Park, MD 21225 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 08/13/2010 Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1 2nd Ave, SW Glen Burnie, MD Singleton Funeral & Cremation Services, P.A. 10135 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Oncet and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (o Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and the burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) Pregnant at time of death cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Tyes Nο 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 25. Was case referred medical examiner? the funeral director, Be 26. Place of Death (Check only one) Hospital: ၉ 1 🗌 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. completed filled in by 4 - Homicide determined City or Town, State within 24 hours a **To the Funeral D** Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. critifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and

State Registrar

Tou

address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

=AFFAR

29c. License number

23

Street Westminster

(Month) Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For Stata Registrar	Otate of Marytane		tificate of D			eg. No.	20242		
	es n		1. Decedent's Name (First, Middle, Last)					Date of Death     Month	h Day Year	3. Time of Death		
	Physici /Medi		GENE S		HUMME	L			09 2010	6:10 A M		
	Examir	er	4a. Facility Name (If not institution, give s			4b. City, Town, or L			4c. County of Deal			
rois,			FUTURE CARE CHERR			REISTE	RSTOWN If Under 24 Hrs.	- 5 - 75:11	BALTIMO			
	Funeral Director	Œ.		7. Age (In yrs. Ia	Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, 07/25/1	926 9. Birt	thplace (State or Foreign buntry) MD		
	land		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits		
	Mary if sh	to	MD BALTIMO	RE I	BALTIM	ORE				1 Yes 2 No		
	h the	irec	10e. Street and Number			10f. Zip Code		10	Og. Citizen of What Co	puntry?		
	th wil	Funeral Director	49 FARMHOUSE COUR	T		21208			USA			
	r dea	ner	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	. 13. V	Vas Decedent of His Yes, specify Cuban	panic Origin? (Spe , Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit			
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Itema 23a or 28a-f show any injury or other traumatic event, I'ta Medical Examinar in ust be invitified at once.	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates:		☐ Yes 2🎇 No	Specify:		HITE			
5-	72 h "natu	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of wo			ng	16b. Kind of Business	Industry		
12	within ene. than *	ш	Elementary/Secondary (0-12)	Coltege (1-4or 5+)		REPRESEN	TATTTE		PHARMACEUT	TCAT		
	Hygie ther ther		17. Father's Name (First, Middle, Last)	4	SALES		18. Mother's Name			ICAL		
Maryland	id be ental ked c	To Be	MORRIS	HUMMEL			CELIA		ZETLI	N		
ary	shoul ind Mi	-	19a. Informant's Name/Relationship (Typ		19b. Mailin	g Address (Street ar		I Route Number,	City or Town, State, 2			
	alth a		HARRIET HUMMEL/WI	FE	49 F	ARMHOUSE	COURT, BA	ALTIMORE	, MD 2120	08		
ore,	es 1 a of He of Hem filtem		20a. Method of Disposition 1XXBurial 2 □ Cremation 3 □ R	ca	ce of Dispos	sition (Name of natory or other place)			20c. Location - City or	Town, State		
Ĕ	Pages ment of ant: If It ury or o		4 Donation 5 Other (Specify)		3 SHAL	OM MEM. P	к. 08/1	1/2010	REISTERST	OWN, MD		
Baltimore,	permit. Departimport Import any inj		21. Signature of Funeral Service License	Vamel		Name and Address	201		ON & BROS. KESVILLE,	•		
П	Tara.		23a. Part1. Enter the disease, or complete shock, or heart failure. List only on	cations that caused the death.						Approximate Interval Between		
	Physician		Immediate Cause (Final disease or condition Atherers clevely (evelya) 1/93 culca disease									
	/Medical		resulting in death)	Due to (or as a conseque		L COV	Mary Or	43401C	413626	years		
4	Examiner		Sequentially list conditions, b									
	pe tis	ine	if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	ence ot):							
_	riticate be executed ng physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	. Due to (or as a conseque	ance of):							
68760,	be es	aiE										
687	ficate physics the	edic	0									
Вох		Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant	3c. ff yes, outcome of pregnan					23d. Date of de	ivery		
	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)						Day Year		
0	at the by th tache	hys	9 🗆 Unknown	9□ Unknown								
	res that the de signed by the a toe detached f	by P	Part II. Other significant conditions con	tributing to death but not resul	ting in the un	derlying cause given	n in Part I.	23e. Did tob	acco use contribute to	the cause of death?		
ord	w require been sis							1 □ Ye	s 2□No 3□Pr	robably 4-5Unknown		
Records,	a 25 C	Completed						24a. Was ar autopsy	y prior to	utopsy findings available completion of cause of		
<u> </u>	ding Physician; The h. h. Atter this certiticate ha funeral director, page	Con						perform 1 ☐ Yes 2		2 □ No		
Division of Vital	Attending Physician: r death. ector: Atter this certification the funeral director.	Be	25. Was case referred to medical examiner?	ospitaf:			26. Place of Death	Check only one	9)			
ō	Phys this ral dir	5.	1 ☐ Yes 2♣No ☐	I Inpatient 2 E	R/Outpatient 28b. Time of		4 Valvuising Hor		nce 6 Other (Spe	cify)		
O	ding h. Atter fune	t lo	1 Autural 5 Pending	28a. Date of Injury (Month, Day Year)	Injury	28c. fnjury a Work? M 1 7	es 2 No	Edd. Describe no	w injury occurred			
S	l or Attencatter death Director: In by the	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At hom	ne, farm, stre			28f. Location (Str	reet and Number or Ri	ural Route Number.		
á	- 9.5	Certification;	4 Homicide	building, etc. (Specify)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town				
	To the Hospital or within 24 hours atter To the Funeral Dir completely tilled in	Medical (	29a. Certifier (Check only one) 12 Certifying Phys	ician: To the best of my know ler: On the basis of examination and manner stated.	ledge, death on and/or inv	occurred at the time estigation, in my opi	e, date and place, a nion, death occurre	and due to the ca ed at the time, da	use(s) and manner as ite and place, and due	s stated.  to the cause(s)		
	To the within To the complex c	Me	29b. Signature and title of certifier			29c. License			9d. Date signed (Mont			
						1	037577	3	August 9	1,7010		
1	./		30. Name and address of person mo co	pleted cause of death (Item 2	23a) (Type, I	Print)			4			
4	V		JOF 3/DOH	WD 583		Smth	Ave 1	5attur	August 9 e MD	<b>705/5</b>		
-8	Sta	-	31. Date filed (Month; Day; Year)	32. Registrar's Signatu	10	20						
	Registr	ar	AUG 1220	and a second	ALC: 160	Chellan.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2010 Year Georgia P. Hazlett August 7 3:05 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Potomac Valley Nursing & Wellness Rockville Montgomery Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Hours Min. (Month, Day, Year) 11y 3, 1915 Arkansas 432-22-3409 95 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland | Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10531 Tanager Lane 20854 United States Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Specify: White If Yes, Give Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Arthur Shaver Agnes Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) D. Jean Ward/Daughter 10531 Tanager Lane, Potomac, Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Gate of Heaven
Cemetery 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State August 16, 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland Pumphrey Funeral Home/ Montgomery Avenue 2010 22. Name and Address of Facility Robert A. Rockville, Inc. 300 West Rockville, Maryland 20850 Signature of Funeral Service Licenses M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Severe Dementia Vears

Physician/ Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi

**Funeral** 

Director

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permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or amy injury or other traumatic event, the Medical Examiner must be 1 once.

notified at

Page 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Physician/Medical signed by the aid be detached for Completed by should 絽

has

After this certificate

after death

e Funeral I within 2

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Anurita Mendhiratta,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Division of Vital Records, P.O. Box 68760

	_ a				J	
	resulting in death)	Due to (or as a consequence of):		_		
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Universe to injury	Due to (or as a consequence of):				
	that initiated events c. resulting in death) Last	Due to (or as a consequence of):				
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	livery Day Year				
	Part II. Other significant conditions conti	ributing to death but not resulting in the underlying cause given in Part I.			the cause of death?	
			24a. Was an autopsy performed? 1 ☐ Yes 2 🔀	prior to death?	ntopsy findings available completion of cause of	
)	25. Was case referred to medical	26. Place of Death (Check	only one)			
	1 L Yes 2 Los No	spital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other:	ne 5 🗆 Residence	6 ☐ Other (Spec	cify)	
	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	28a. Date of injury (Month, Day, Year)  28b. Time of injury  28c. Injury at work?  1 □ Yes 2 □ No	28d. Describe how injury occurred			
	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	(Check 2 Medical Examine)	an: To the best of my knowledge, death occured at the time, date and place, and r: On the basis of examination and/or investigation, in my opinion, death occurred at t Practioner: To the best of my knowledge, death occurred at the time, date and place	the time, date and place	ce, and due to the	cause(s) and manner stated.	

29c. License number

D38262

MD 2401 Research Blvd. #330, Rockville, Maryland 20850

29d. Date signed (Month, Day, Year)

August 10, 2010

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20°10 August 11 10:30 AM John Lewis Lutz Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 XM 2 □ F Months Days Hours AUG 16. 66 Director 1943 Pennsylvania 215-40-0853 Usual Residence of Decedent or 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at Director MD Harford Aberdeen 1 🗌 Yes 2 🗶 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 731 Cronin Drive 21001 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. Completed by 1 Never Married 2 X Married ☐ Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 XNo Specify: Specify: 3 Divorced 4 Divorced White other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Sales Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ John Α. Lutz Florence Cox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Torinda J. Lutz, wife 731 Cronin Drive Aberdeen, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Department of P Important; If ite any injury or ot once. ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory, Inc. 08/12/10 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Gram NEGATIVE disease or condition resulting in death) # 1 Medical Due to (or as a consequence of): **Examiner** 莊 PARUMONIA Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consultance of signed by the attending physician and de detached for use as the burial-transit K UO5 3005 4 8/11 | 10 1030 am Division of Vital Records, P.D. Box 68760 that initiated events resulting in death) Last Due to (or as a consequence of): Certificate: To Be Completed by Physician/Medical ISSERIMATEN IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Dav Year 1 Yes 2 u 9 Unknown To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached it Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 1 7 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 2-No 2 - N 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital or within 24 hours aff To the Funeral Di 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gettifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 8/11/10

DHMH 17 Rev 7/2009

State

Registrar

ChasAPGAKE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

500

AUG 12 2010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#30perDVR, G906.8/12/2010 WS
State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Aug. 9, <sup>Day</sup> 2010 Physician/ Lloyd Virginia Irene Ash 9:45 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Columbia Examiner 4c. County of Howard County of Death 10101 Governor Warfield Parkway Apt 360 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 XX Months Hours Min. Greenwich, CT Director 040 22 0345 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🏋 No Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10101 Governor Warfield Parkway Apt 360 21044 United States within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Hame Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Matthew H. Ash Ethel M. Shuttleworth other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Lloyd (SON) 12221 Van Brady Road, Upper Marlboro, MD 20772 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 XX Surial 2 Cremation 3 Removal from State Cedar Hill Cemetery Aug 14, 2010 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 33 m015 Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final MYGCAROIGE INFAR CTION Pilysician disease or condition resulting in death) Medical Due to (or as a consequence of) Examine DRUNARY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir Cause (Disease or iinjury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death 5 Other (specify) signed by the a d be detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CHRUNIC ATRIAL FIBRILLATION Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed CONGESTIVE HEAZT FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed certificate 2 🗆 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) a examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Director: After this d in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending hours after death. 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide determined within 24 hours a

To the Funeral C

completed filled i Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific D ØØ67273 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alt. M.D. SH Johns Hopkins Community Physicians Columbia, MD 32. Registar's Signatus State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Eileen Μ. Loughran 2010 August 7:37 рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist If Under 1 Year If Under 24 Hrs. . Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🛛 F Days Hours Min Oct 22, 1942 MaryTand 67 **Director** 214-74-7803 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Baltimore Timonium Md. 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 USA 2520 Pot Spring Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 X Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) None Disabled 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Kathleen Fiddes Hugh Loughran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21125 Ridge Rd. Freeland, Md. 21053 Ms. Kathleen Kirk/ Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 

Burial 2 

Cremation 3 

Removal from State 8-11-10 Hilltop Service Co. Towson, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licen <sup>22. Name and Address of Facility</sup> KUCK Towson Funeral Home, 1050 York Rd. Towson, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final FallUN Physician/ disease or condition resulting in death) Renal Acure Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury use as the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): been signed by the attending physician should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe 2 No 1 🗌 Yes Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗀 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check only on Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AANON 31. Date filed (Month, Day, Year

**AUG 12** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State	te of Maryland		nt of Health and te of Death		ie <u>2</u> e0   0	25247
			Registrar  1. Decedent's Name (First, Middle, Last)				2. Date of Deat		3. Time of Death
	Physicia		MARTHA		MADD	OV	Month	Day Year	М
	/Medic		4a. Facility Name (If not institution, give street a	nd number)		, Town, or Location of Dear	08	09 2010 4c. County of Dea	
	Examin	er	2032 RUXTUN	\		HLTIMORE		BALT	-
			5. Social Security Number 6. Sex	7. Age (In yrs. last		er 1 Year If Under 24 Hrs		9. Bir	hplace (State or Foreign
	Funeral Director		215-12-7356 1 M 25		Yrs. Months	Days Hours Min		Year) Co	MD
		. }	Usual Residence of Decedent	- 91			0/ 11	19	TAD
	land ow	Ì	10a. State 10b. County	10c. City, To	own or Location				10d. Inside City Limits
	Mary Fah	Į.	MD NA	р	altimor	^			1∏Yes 2∏No
	the 28a	Director	10e. Street and Number			ip Code	1	0g. Citizen of What Co	puntry?
	3a oi		2022 5 1			21216			
	na 2:	era	2032 Ruxton Ave	Decedent Ever in U.S.	13. Was Dec	21216 edent of Hispanic Origin? (\$	Specify Yes or No-	14. Race - Ame	
<b>'</b> 0	r iter	Funerai	Am	ed Forces? Yes <b>2√</b> □ No es, Give		ecify Cuban, Mexican, Puer	to Hican, etc.)	Black, Whit	e, etc.
ဗ္ဗ	urs e	by	3√ Widowed 4 Divorced Year	es, Give ir or Dates:	1 🗆 Yes	2  No Specify:		Specify: I	Black
Ö	tiled within 72 hours efter deeth with the Maryland Hyglene. Hyslet han "natural", or tlema 23a or 28a-f ahow ent, the Medical Evain or must be notitled at	Completed	15. Decedent's Education		6a. Decedent's Us	ual Occupation rork done during most of wo		16b. Kind of Business	
2	hin 7 e. nn "n	pie	(Specify only highest grade comp.  Elementary/Secondary (0-12) Col.	lege (1-4or 5+)	life. DO NOT	use retired)	n kang	Baltimore	e City
21215-0036	d wit	тo	3 3 4 1		hysical	Therapist	Aide	Public So	chools
ਕੁ	otho	Bec	17. Father's Name (First, Middle, Last)		•		me (First, Middle, I	Maiden Sumame)	
<u>m</u>	Alenta Alenta rked tic e	ToE	James Jiggettes			Emma Y	erby		
Maryland	permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Marylan Department of Health and Merial Hyglene. Important: if items 27 is marked other than "natural; or items 23a or 28a-f show arry injury or other traumatic event, the Medical Examination in the collines and once.		19a. Informant's Name/Relationship (Type, Prin	nt) 1	19b. Mailing Addre	ss (Street and Number or R		, City or Town, State,	Zip Code)
Σ	alth alth 27 is		Norma Coles-Daught	er	2032 Ru	xton Ave,	Baltimo	re, Md 2]	216
Baltimore,	s 1 a if Hei item othe		20a. Method of Disposition	20b. Place	e of Disposition (Netery, crematory or	ame of		20c. Location - City or	
Ë	Pege ent c nt: If ry or		1 Sp Burial 2 ☐ Cremation 3 ☐ Remova `4 ☐ Donation 5 ☐ Other (Specify)	from State	edar Hi		9/2010	Baltimor	e. Md
≣	artm ortal		21. Signature of Engleral Service Licenses	~ // /		and Address of Facility	J, 2020	Darcimo	
ä	Ped ding		Karento	Mahan	Marc	n r/H west Wabash Ave	a. Balti	more. Md	21215
			23a. Part1. Enter the disease, or complications	that caused the death. I					Approximate
			shock, or heart failure. List only one caus Immediate Cause (Final		DEME	(= ) A			Interval Between Onset and Death
	Physician /Medical		disease or condition a	SENICE ue to (or as a consequen		J ( ) ( )			
	Examiner			,	ice oi).				
		- G	Sequentially list conditions, if any, leading to immediate	ue to (or as a consequen	ice of):				
J.	ted nslt	in	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury						
~ <b>.</b>	al-tra	Examiner	that initiated events c	ue to (or as a consequen	ice of):				
8760,	The law requires that the death certificate be executed tie has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	dicai E							
687	phy:	olbe	G						
×	eath certific ettending p I for use as	by Physician/Me	IF FEMALE: 23c. If your 23c. If your 23c. If your 23c. If you 23c.	es, outcome of pregnancy	/			23d. Date of de	livery
Вох	eath etter for u	clar	in the past 12 months?	Live birth 2 Fetal de Pregnant at time of death				Month	Day Year
o.	the d the ched	isi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	Unknown					
<u>α</u>	res that the death signed by the etter be detached for u	/ P	Part II. Other significant conditions contribution	g to death but not resultin	ng in the underlying	cause given in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
ds	sign d be	d b					1 🗆 Y	es 2 No 3 P	robably 4 Gunknown
Ö	v requir been si should	ete					24a. Was a	n 24h Were a	utopsy findings available
Records,	has has	Completed					autops perfor	y prior to	completion of cause of
							1 ☐ Yes	2 No 1 □ Ye	s 2 No
Vital	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?  Hospital			04	eath (Check only or		
	Physical this direction of directions of the direction of	ို	1 185 2 NO	1   Inpatient 2   ER	/Outpatient 3 []	JOA 4 Nursing		ence 6 Other (Special Company)	ecify)
Ë	ding F h. After funer	on	1 Natural 5 Pending	(Month, Day Year)	Bb. Time of Injury	28c. Injury at Work?	28d. Describe III	ow injury occurred	
S	death ctor: A	cat	2 Accident investigation 3 Suicide 6 Could not be	Discontinuos Athene	M	1 Tes 2 No	28f Location /S	treet and Number or F	Jural Route Number
Division of	or Attended efter death Director:	Certification;	4 Homicide determined	Place of Injury - At home building, etc. (Specify)	e, rarm, street, facto	ory, office	City or Tow		urai Fioria ivaniber,
	To the Hospital or Attending Physicien: within 24 hours elfer death. To the Funerel Director: After this certific completely filled in by the funerel director,		On Codifice	T- 45 - 5 - 5 - 5 - 5 - 5	alam alama	d - 1 (1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	and due to the	augg(a) and masses	e stated
	Hosp 14 ho Fune fely f	ica	29a. Certifier (Check only one) 1 Certifying Physician: 2 Medical Examiner: Or	the basis of examination					
	To the Hospital within 24 hours e To the Funerei I completely filled	Medical	29b. Signature and title of certifier	d manner stated.	9	9c. License number	2	29d. Date signed (Mor.	th, Day, Year)
1	N N N								
7	1			м	37	DS7722		AUGUST 1	0 2010
	6		30. Name and address of person who complete			TO:55 0104	a Lam 4	11500016 .	10 21254
			LEUNAND RICHARDSON	32. Registrar's Signature		TREE RUAL	# 500	ricesvice p	11 61208
	Sta Registr		31. Date filed (Month, Pau Gear) AUG 12 2010	Self-indicated a Signature	A Brown				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		ryiano		ertificate of			g. No. U	0 252		
	Physici		Decedent's Name (First, Middle, La.	Calvin	L.	McI1	wain		2. Date of Death Month August	9, Day 2010	3. Time of 8:35	P M	
~	/Medic Examin		4a. Facility Name (If not institution, giv				4b. City, Town, o	r Location of Dea		4c. County of			
c.			Manor Care Ros				Rose				imore		
	Funeral Director		5. Social Security Number 102–16–5376  Usual Residence of Decedent	ex 7.Age ▼ M 2□ F	(In yrs. la 87	st birthday Yrs.	Months Days	If Under 24 Hr. Hours Min		Year) 9 1923 N	Birthplace (State of Country)  orth Caro	r Foreign 1ina	
land			10a. State 10b. County		10c. City,	Town or L	ocation				10d. Inside Cir	ty Limits	
Ind 21215-0036  be filed within 72 hours after death with the Maryland ital Hydiene.	a-fsh	ctor	MD Balti	more			Rose	eda1e			1 □Yes	2 <b>X</b> No	
	with the	Funeral Director	10e. Street and Number 2022 Flintshire	Road Ant	202		10f. Zip Code	21237	1	0g. Citizen of Wha	at Country?		
	ns 23	era	11. Marital Status	12. Was Decedent E		. 13	Was Decedent of H		Specify Yes or No-	14. Race -	American Indian,		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, It is in first for it is the confined at once.		1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces? 1	o		If Yes, specify Cuba 1 ☐ Yes 2 ★ No	Specify:	rto Rican, etc.)	Specify:	White, etc. <b>Black</b>		
2- 2-	72 hou	Completed by	15. Decedent's Ec (Specify only highest gra	lucation			edent's Usual Occup		orkina I	16b. Kind of Busir	ness/Industry		
2	itthin ne.	mple.	Elementary/Secondary (0-12)	College (1-4or 5+	)	`life.	DO NOT use retired	d)	Sitting .	A = = = = = = = = = = = = = = = = = = =	<b>.</b>		
2	iled w Hygie ther th		17. Father's Name (First, Middle, Last)			юа	okkeeper	18. Mother's Na	ame (First, Middle, M	Account	ing		
au	d be f ental ked ol	To Be	Unk.					Em		, , , , , , , , , , , , , , , , , , , ,	McIlwai	n	
ary	should and Mer s marke umatic	۳	19a. Informant's Name/Relationship (	Type. Print)		19b. Mai	ing Address (Street		Rural Route Number	City or Town, St		11	
ž,	and 2 ealth a n 27 is ner tra		Maxine A. Beckett	, daughter		2022	Flintshi	e Road.	Apt. 202	Roseda1	e, MD 21	237	
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐	Removal from State	20b. Pla		osition (Name of ematory or other plac		Date	20c. Location - Cit	ty or Town, State		
Ē	Pages tment of l tant: If ite		4 ☐ Donation 5 ☐ Other (Specif	y)					11/10				
Baltimore,	permit. Page Department ( Important: If any injury or once.		21. Signature of Funeral Service Licer	See George	1acNa	lebb   2			remation ad Balti			c.	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	plications that caused to one cause on each line			nter the mode of dyi	ng, such as cardi	ac or respiratory arre		Approximate Interval Bet Onset and I	e ween Death	
white of the	Physician /Medical		disease or condition resulting in death)	a Due to (or as a			ic C	TICES	_				
	Examiner			Duc to (01 a3 a	conseque	Tibe 01).							
5		ner	Sequentially list conditions, if any, leading to immediate cause characteristics and the conditions that initiated events  Due to (or as a consequence of):  Due to (or as a consequence of):  C.										
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C									
68760,	rificate be executed ig physician and as the burial-transit	al E	Toolang III dodany Zaot	Due to (or as a	conseque	ence oi):							
687	tificate ig phys as the	ledical		_ d				-					
	ath cer	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 9 Unknown	□ Fetal o	death 3	☐ Ectopic pregnand	sy		23d. Date of Month		Year	
<u>Р</u>	nat the d by ti etach	Phy	9 Unknown			Marie de Alexandre		and in Death	OGo Did tol	acco use contrib	ute to the equipe of c	doath?	
Records,	uires that the de signed by the a Id be detached f		DENE N								s 2 No 3 Probably 4 Lunknown		
Ö	w requir s been s s should	Completed							24a. Was a	n 24b. We	ere autopsy findings or to completion of c	available	
æ	The lav	mo m							- autops perforr 1 ☐ Yes	ned? dea	or to completion of c ath? ∃Yes 2 □ No	ause of	
Vita	ysician: The is certificate director, pag	Be C	25. Was case referred to medical examiner?					26. Place of De	eath (Check only on				
<u></u>	Physic this ce		1 Yes 2 No				ent 3 DOA Oth	4 X Nursing	Home 5 ☐ Reside		* *		
n C	ding P h. After funera	ion:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)	Year)	28b. Time Injury	Wor		28d. Describe ho	w injury occurred			
Division of	Attenc death ctor; y the	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	100	v - At hon	ne. farm. s	treet, factory, office	Yes 2 □ No	28f. Location (St	reet and Number	or Rural Route Num	nber.	
2	tal or Attendii s after death. al Director; A ed in by the fu	Certification: To	4 ☐ Homicide determined	building, etc.	(Specify)	, , .	, , , , , , , , , , , , , , , , , , ,		City or Town	n, State)		,	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificat completely filled in by the funeral director, to	Medical (	29a. Certifier (Check only one)  1	ysician: To the best o niner: On the basis of and manner stat	examinati	rledge, dea on and/or	ath occurred at the ti nvestigation, in my	me, date and pla opinion, death oc	ce, and due to the c curred at the time, d	ause(s) and mani ate and place, an	ner as stated. d due to the cause(s	3)	
	To the company	Me	29b. Signature and title of certifier	· ^			29c. Licens				Month, Day, Year)		
			Emy Wheles	JL.			D00	60560	A	NGUST	11,2010		
\			30. Name and address of person who PANKAT KWETER	- 0	ath (Item	23a) (Type	, Print)	Pat	, A	A1714.5	RE MAN		
ì	Sta	te	31. Date filed (Month, Day, Year)	32 Registra	r's Signatu	ire	PLIKIT	, <del>-</del> 9 -	~ U & , 15	17) -111NO	1-0 1100		
	Registr	ar	AUG 1 2 201	1) and	1	. Apr	ald						

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death 2 Date of Death 3. Time of Death Physician/ Month 23:13 DM Medical 4a. Facility Name (if not institution, give street and number) Jown, or Location of Death **Examiner** 4c. County of Death HOSPITA samaritan 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) Funeral If Unde 8. Date of Birth Months 70 **Director** or 28a-f show 10a. State "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 XYes 2 □ No 10e. Street and Number 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⚠ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married ģ 3altimore, Maryland 21215-0036 1 Yes 2 No Black 3 Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) onday (0-12) College (1-4 or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Youn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Maple Hill Koua lessa Moon 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemptery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Engleral Tervice Censee

22. Name and Address Vaughn C.

23a. Part 1. Enter the disease, or proper gives one cable like the death. Do not enter the mode of dying, and the death of benefit follows. Approximate Interval Between shock, or heart failure. List only one cause on each line rediate Cause (Final ase or condition line in the cause) Immediate Cause (Final disease or condition resulting in death) Onset and Death Respiratory failure Physician, percabnic Medical Examiner phea. Chronic obstructive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit PU/Monary that initiated events resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death
Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ End stage Renal disease, Hypertension Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown Cirrhosis, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autonsy 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 🗌 Yes 2 🗆 No Natural injury within 24 hours after death.

To the Funeral Director: A 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 65000

Registrar DHMH 17 Rev 7/2009

SANTOSH 31. Date filed (Month, Day, Year)

/32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Blvd. Good Samonton Huspital

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 2:50 PM 5 Juanita Elizabeth McGuire 010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner University Specialty Hospital Baltimore 8. Date of Birth (Month, Day, Ye Feb. 25, If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Year. Days 1 □ M 2 🕅 F 219-30-4836 75 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State r 28a-f show notified at 1 ¥Yes 2 No Funeral Director Delaware Sussex Selbyville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or 2 must be n 36929 Blue Bill Drive 19975 USA 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 'natural'; or items dical Examiner ma 11. Marital Status l □ Yes 2 🔯 No f Yes, Give ∕ear or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Social Security Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygienn Important: If item 27 is marked other the any injury or other traumatic event, the once. Administration Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( Anthony Joseph Aquilla Mary Louise Thompson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Michael J. McGuire Son 6 Ridge Farm Court; Cockeysville, MD 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Crestlawn Mem. Gardens 8/9/2010 | Marriottsvile, MD | 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 5 Other (Specify) 4 □ Donation 21. Signature of Progral Service MD 21228 1630 Edmondson Avenue; Catonsville, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) intra Cranial months Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. þ thrombo3 4 Unknown 2 No 3 Probably 1 TYes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy Kes pender 25. Was case ref rred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To Inpatient this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **(**5) harles Chreet. State

DHMH 17 Rev 1/2001

Registrar

MCGUIRE, JURNIGA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AUIN Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Seasons Hospice <u>Randallstown</u> Baltimore 7 Age (In vrs. last birthday 9. Birthplace (State or Foreign Country) New York Social Security Number 6. Sex 8. Date of Birth **Funeral** Days Hours Min 1 X M 2 🗆 F Months August 16.1921 88 **Director** 213-14-0922 show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director r 28a-f sl notified Maryland Baltimore Gwynn Oak 1 🗆 Yes 2 ื No 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 6811 Campfield Rd. U.S.A. 21207 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 X No Black, White, etc. 5 þ 1 Never Married 2 Married Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: "natural", 3 X Widowed 4 Divorced Specify: White Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Lutheran Minister Church it. Page 1 and 2 should be filed with them of Health and Mental Hygien rtant; If item 27 is marked other 1 njury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Manrodt Manfred Martha Muller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas P. Manrodt - Son HC 61 Box 5068 Ramah, NM 87321 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Department o Important: If any injury or Parkwood Cemetery 8/14/10 4 Donation 5 Other (Specify) Baltimore, MD 22. Name and Address of Facility 21. Signatur of Funeral Service Licenses Baltimore, Maryland 21214 Inc. 5305 Harford Rd . Part 1. Enter the disease, or complications that of used the death. Do not ente shock, or heart failure. List only one cause on each lipe. Approximate nterval Between Inset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to (or as a consequence of): burial-transi and Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the buri Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Gertifying Nurse Practioner: To the best of my knowledge et the time dete 29b. Signature and title of ne and address of person completed cause of death (Item 23a)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend \$20b cate of Maryland Department of Health and Mental Hygiene = For State Registrar 25252 Reg. NZ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year OLALEYE ADENIKE 5:20 PM AUGUST 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE RANDALLSTOWN HOSPITAL NORTHWEST If Under 1 Year If Under 24 Hrs. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. (Month, Day, Year) Months Days 1 - M 2 F Hours Country) Nigeria Director 9-47-4150 52 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director Randallstown 1 Tes 2 X No Baltimore MD 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? Funeral 23a 9209 Turnbull 21133 U.S.A. Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ö Completed by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 No Specify: Black Specify: 'natural", 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Private Duty 2yrs+ Nurse 2thgrade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked of ၉ Ramota Akinlade Tiamiyu Akinlade 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 9209 Turnbull Road, Randallstown, Md 21133 James Olaleye-Husband
20a. Method of Disposition Baltimore, 20b Nince of Sepportion (Name of ed 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Randallstown Woodlawn, Methodist Church King Memobial Park 8/28/2010 Signature of Auneral Service Licensee Marke and Address of Facility, 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that cause 1 the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Annrovimate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death lediate Cause (Final Physician/ BRAINSTEM HERNIATION disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner CEREBRAL EDEMA MINUTES Sequentially list conditions, if any, leading to immediate cause. Enter underlying Examine Due to (or as a consequence of) 30 MINUTES Cause (Disease or iinjury ANOXIA that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 29 HOURS STATUS ASTHMATICUS the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 XNo 2 **X**N 1 🗌 Yes Yes 24 hours after death.

• Funeral Director: After this certificalleted filled in by the funeral director, to 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State, Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the I only one) 29d. Date signed (Month, Day, Year) 29c. License number AUGUST 3, 2010 00060293 person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 5401

AHMED

31. Date filed (Month, Day Year)

M.D.

OLD COURT ROAD.

RANDALLSTOWN, MD 21133

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ PLISINSKI **JEANNETTE** C. AUGUST 8 2010 6:00am Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 800 CHESTER ROAD BALTIMORE MIDDLE RIVER 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 😾 F Months Days Hours Min. 039247 1950 207 40 2093 PENNSYLVANIA 60 Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d, Inside City Limits Directo PA KING OF PRUSSIA 1 Tes 2 X No MONTGOMERY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 477 ORCHARD ROAD 19406 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ō 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 WHITE 1 Yes 2 No Specify Specify "natural" 3 Divorced Completed Year or Dates 1 and 2 should be filed within 72 houns of Health and Mental Hygiene.
Item 27 is marked other than "natur other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SECRETARY GENERAL BUSINESS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည CHARLES CAMPBELL SR. **JEANNETTE** REXROAD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GARY J. PLISINSKI/HUSBAND 477 ORCHARD ROAD KING OF PRUSSIA, PA 19406 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of F Important: If ite any injury or oth 1 🗌 Burial 2 💆 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 8/11/10 BALTIMORE, MD 21. Signature of Fun-CVACH/ROSEDALE FUNERAL HOME AVE BALTIMORE, 1211 CHESACO 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Pregnant at time of death 1 Yes 2 No the Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 diso de Division of Vital Records, 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ours after death.

eral Director: After this certificate has filled in by the funeral director, page 2 s autopsy 2 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 🗆 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 A Other (Spe 28a. Date of injury (Month, Day, Year) 28b. Time of 27, Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending work? 1 Yes 2 No М Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 24 hours a Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. соmpleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Ma 2010 completed cause of death (Item 23a) (Type, Print) Springs Rd Bryn Howr, & ML 31. Date filed (Month, Day, Year) 32. Regi

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 25254 State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Tae Hee Pak 8:32 AM 2010 <u>August</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Baltimore 1600 W Mount Royal Avenue Apt 308 If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** July 9, 1938 1**X** M 2 □ F 72 Yrs. 576-86-5629 Korea Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Maryland N/A Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21217 Korea 1600 W Mount Royal Avenue Apt 308 within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 <sub>Specify:</sub> Asian If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 Widowed 4X Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Janitor Cleaning Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Page 1 and 2 should be filed tment of Health and Mental H tant: If item 27 is marked otl Sun Pak 0k Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Suk Han, Sister 245-21 60th. Avenue Little Neck, NY 11362 Department of Heali Important: If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 08/11/10 Metro Crematory Inc. Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licenses Crematory Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Thomas Gregor Skomai 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset an Death Immediate Cause (Final Physician/ days neumonta disease or condition resulting in death) Medical Du to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a conseduence of or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician about the burial be detached for use as the burial. Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death ☐ Yes ∠ \_ ☐ Unknown Yes Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by eukemia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown renal Insufficience 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 1 ☐ Yes 2 ☐ No Yes 2 1 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home Hospital: 1 ☐ Yes 2 ¥ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 ■ Residence 6 □ Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending death. Accident Investigation the within 24 hours after deal To the Funeral Director: Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. completed filled in by 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29b. Signature and title of certifier

Xas

30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

M.D.

noo

32. Registrar's Signature

29c. License number

Gerpe Rd #204

5.2544

29d. Date signed (Month, Day, Year)

AUG 11,

Catonsville.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 01:39AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltmor Hospitan Sewn If Under 1 Year If Under 24 Hrs Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Month, Day 1 🗆 M 2 🗶 F Months Days Hours Min Year 956 220-64-5828 MD Director 54 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Yes 2 No BALTO MD na 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 21216 2817 Riggs Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 2**X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black Specify: 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Disabled Disabled llth grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Elsie Bonds Thomas Bonds 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2526 Hollins Ferry Road Balto, MD 21230 Thomas Bonds-Brother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Memorial Pk Randallstown, MD 8-10-2010 King 4 Donation 5 Other (Specify) East F/H March 21. Signature of Fundral Service Lig 22. Name and Address of Facility MD 21202 1101 E. North Avenue Balto, 23a. Part 1. Enjor the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ myocardial disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any learn, immediate cause. Enter Underlying Cause (Disease or linjury Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi stag that initiated events Due to (or as a consequence resulting in death) Last by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No for Pregnant at time of death 5 Other (specify) 1 Lyes 2... 9 Unknown be detached g | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Inknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe certificate 1 Yes 2 LNG within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to redical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 Hospital 2 No 1 🗌 Yes 1 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 2 Inpatient 3 Inpa 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. injury at 28d. Describe how injury occurred Certificate: Natural 5  $\square$  Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours after To the Funeral Direc Medical 29a Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. attending 2 Cost mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

2000. W-Baltimore

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Bon Sewur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OSCAR BURNS POLLARD  $10:00p^{M}$ 2010 AUGUST Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE SEASONS HOSPICE AT NORTWEST HOSPITAL RANDALLSTOWN 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 🔀 M 2 □ F 88 231-18-9306 VIRGINIA **Director** Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10c. City, Town or Location aţ 10a. State 10b. County Director Examiner must be notified BALTIMORE 1 X Yes 2 No N/A MD. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō Funeral 23a21216 USA POPLAR GROVE items death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 0 ò 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify. Specify: BLACK 3 🖟 Widowed 4 🗆 Divorced "natural", Completed traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) KOPPERS MECHANIC Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ LULA POLLARD HENRY POLLARD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 901 POPLAR GROVE ST. BALTIMORE, MARYLAND 21216 JERRI POZLARD (DAUGHTER) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burial 2 Crem ion 3 Removal from State 8-14-2010 BEULAH BAPT CHURCH CEM. 5 D other (Specify) MINOR, VIRGINIA 4 Donation HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature of MARÝLAND 21217 BALTIMORE, 1721-27 N. MONROE ST. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, for heart failure. List only one cause on each line. Approximate Interval Between shoc Onset and Death Immediate Cause (Final Physician/ las anlar disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate and I-transit Exam The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last physician a the burial-1 Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death n signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 nknown Completed To the Hospital or Attending Physician: The law require within 24 hours after death.

To the Funeral Director After this certificate has been si completed filled in by the funeral director, page 2 should 1 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Stether (Specify) 1 pahor 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA မှ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: work? injury 1 Natural 5 Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) nona Miller mo 8/10 Da7683 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimon MD Kan 21209 2835 gistrar's Signature

DHMH 17 Rev 7/2009

State Registr<u>ar</u>

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. N2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Manth August 20m 11:35 William James Reed Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgamery Rockville Collingswood Nursing Hame If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Sex 1 X M 2 □ F **Funeral** Months VA Director 85 219-12-5037 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director Rockville MD Montgamery 1 🗌 Yes 2 🛛 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14643 Bauer Drive, Apt. # 318 20853 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⚠ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 African-American 1 ☐ Yes 2 No Specify. Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Clerk DC General Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Parham Fixene Reed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3739 Nortonia Road, Baltimore, MD 21216</u> Bernard Proctor/ Cousin 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State Garrison Forest Veterans: 8-13-2010 Owings Mills, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Whie Funeral Home P.A. of Balto. Co. Sign wre of Funeral Service Licensee Randallstown, MD 21133 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Egguentially list sonditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence-To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown Month Year Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death. Funeral Director: After this certificate has autopsy performed. Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 X Nursing Home 5 Residence 6 Other (Specify) X No မ 3 DOA 1 ☐ Inpatient 2 ☐ ER/Outpatient 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check only one 29b. Signature and title 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

Name and address of person who completed cause of death (Item 23a) (Type, Print)
 Dr. Ahmed Heshmat 10301 Georgia Avenue, Sui

32. Registrar's

31. Date filed (Month, Day, Year) AUG 12 2010 120057

Suite 203, Silver Spring, MD 20902

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Ronald Carl Reuter 2010 August 7:00 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Greater Baltimore Medical Center Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1 🗓 M 2 🗆 F Mary Tand 171071939 214-36-8471 71 Director Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Examiner must be notified at Director Lutherville Baltimore Maryland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Completed by Funeral 21093 910 Morris Ave U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 1 Yes 2 X No If Yes, Give 1 Never Married 2 X Married Specify: White 1 Yes 2 X No Specify: 3 🗌 Widowed 4 🗀 Dîvorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Master Electrician 15. Decedent's Education 16b. Kind of Business Industry Baltimore, Maryland 21215-(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ruth A. Blunt Carl Reuter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 910 Morris Ave. Lutherville, Maryland 21093 Joan P. Reuter / Wife 20a. Method of Disposition
1 □ Burial 2 🗡 Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Hilltop Serv. Corp. 8/11/2010 Towson, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Euneral Service Licenses 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Sepsi Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner penia Sequentially list conditions, if any, leading to immediate cauce. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Pregnant at time of death signed by the a 1 Yes 2 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed been si 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed?

1 Yes 2 No After this certificate has funeral director, page 2: 25. Was case referred to medical examiner? Be ( 26. Place of Death (Check only one) Other: ျှ 1 🗌 Yes 2 WNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident work?
1 Yes 2 No Investigation within 24 hours after death
To the Funeral Director; ≠
completed filled in by the f 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0060721 2010 M. 1) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 North Charles Street Baltimore MD 21204 Koluardo

DHMH 17 Rev 7/2009

Registrar

**AUG 12** 

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death 1:05AM **Physician** Lucille Romine 201 Nancy /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** CAM HARFOR If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/04/1930 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday **Funeral** Days Months Min 1 □ M 2 1 F 80 Yrs Maryland Director 213-28-1620 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show is marked other than "natural", or items 23a or 28a-f shot aumatic event, the "medical Evandral", and the nutthern and 1XYes 2 No Aberdeen Harford Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21001 USA Apt. 2A 1017 Warwick Dr., Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√CXNo Specify: White 3XXVidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) manufactoring laborer 10 Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be fand Mental Mary Singleton ည Phillip May 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sl Department of Health an Important: If item 27 is r any Injury or other traur 1017 Warwick Dr., Apt 2A, Aberdeen, MD 21001 Veronica A. McClendon (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Ferris & Company 08/11/2010 West Chester, PA 4 ☐ Donation 5 ☐ Other (Specify) Aberdeen, Maryland 21001 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ung Cancer /Medical Due to (or as a consequence of): Examiner chim tre Pilnomy pieces EWD STAGE

Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transi and Due to (or as a consequence of) Box 68760 attending physician law requires that the death certificate be Physician/Medical the 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for L in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐No P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy Hospital or Attending Physician; The certificate 1 ☐ Yes 2 No Division of Vital 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 P Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No After this 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 5 ☐ Pending Investigation 1 Natural death. 1 ☐ Yes 2 ☐ No n 24 hours after death.

Reference of the filled in by the filled in by the filled in 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 🖒 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the within To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

10191

Mail Rd Bel

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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TVIP MCLVYP

AUG 1 2 2010

10-05976	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Sabrina Annette Sykes	State of Maryland / Department of Health and Mental Hygiene
1- For State	Cartificate of Dooth

		1- For State Certificate of Death	Reg. No. 2010 055
Physic		Decedent's Name (First, Middle,Last)	2. Date of Death  Month  Day  Year  3 Time of Death
Medical Exam	ine	Saprina Sykes	August 9, 2010 0453 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location 2108 Presbury Street Baltimore	of Death 4c. County of Death
Funeral			er 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or
Director		212-78-9811 1 M X F 52 Yrs. Months Days Hours	
		Usual Residence of Decedent	II   OI   37     "   MD
v any		10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
Maryland 28a-f show d at once.	5	MD NA Baltimore	1 X Yes 2 No
Mary r 28a- ed at	Director	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
ith the Maryland 23a or 28a-f sho notified at once.		211 Ballou Court 21231	U.S.A.
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married Armed Forces? 13. Was Decedent of Hispanic Original If Yes, specify Cuban, Mexican	
ter de ", or i		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 3 No specify.	Specify: Black
1215-0036 Id be filed within 72 hours after femal Hygene. narked other than "natural", event, the Medical Examiner	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give	kind of work done 16b. Kind of Business/Industry
2	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life, DO NOT	use retired)
21215-0036 uid be filed within 72 Mental Hygiene. marked other than "	ш	12th grade na Nurse Aide	Health Care
15-0 iled w Hygid d other	S		r's Name (First, Middle, Maiden Surname)
2121 ould be fil Mental F marked c event, 1		Earl Sykes   Shi: 19a. Informant's Name/Relationship (Type, Print)   19b. Mailing Address (Street and Num	rley Shearn
D 2 shoul and N 7 is n	P <sub>C</sub>		nber or Rural Route Number, City or Town, State, Zip Code)
ore, MD 21218 ges 1 and 2 should be fill tof Health and Mental H : If item 27 is marked other traumatic event, it		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	rt, Baltimore, Md 21231  Date   20c. Location - City or Town, State
Baltimore, M permit Pages I and 2 Department of Health Important: If item 2 injury or other traum		1 X Burial 2 Cremation 3 Removal from State crematory or other place)	
Itim ii. Pa urtmer ortan ry or		4 Donation 5 Other Specify: Bushy Park 21 Signet are of Funeral Service Leonsee 22. Name and Address of Eacility	8/16/2010 Clarksville, Md
Balti permit. Departu Import	_	March F/H Wes	st Ave, Baltimore, Md 21215
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca	ardiac or respiratory arrest, shock, or heart Approximate Interval
/Medical		failure. List only one cause on each line.	Between Onset and
C		Immediate Cause (Final disease a Methadone and Alcohol Intoxicat	
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Methadone and Alcohol Intoxicat  Due to (or as a consequence of):	
Examiner	1.	or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.	
Examiner	niner	or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Ever Undaryth & Cause.	
	xaminer	or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):  Due to (or as a consequence of):	
	al Examiner	or condition resulting in death)  Sequentially list conditions, if any, leading to immediate rank E for Undaryh & Caus (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.	ion Death
		Due to (or as a consequence of):    Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   Due to (or as a consequence of):    Z UNPENDED   AMENDED   AMENDED   AMENDED   AMENDED   AMENDED   AMENDED   8	ion Death
60, cate be executed physician and he burial - transit	Medical	Due to (or as a consequence of):    Sequentially list conditions, if any, leading to immediate rank E for Underlying Course (Disease or injury that initiated events resulting in death) Last    X UNPENDED	ion Death  -27-10 vt  23d. Date of delivery
60, cate be executed physician and he burial - transit	cian/Medical	Due to (or as a consequence of):    Sequentially list conditions, if any, leading to immediate consider the second properties of the second proper	ion Death -27-10 vt
60, cate be executed physician and he burial - transit	sician/Medical	Due to (or as a consequence of):    Sequentially list conditions, if any, leading to immediate considered events resulting in death) Last   Due to (or as a consequence of):	ion Death  -27-10 vt  23d. Date of delivery
60, cate be executed physician and he burial - transit	Physician/Medical	Due to (or as a consequence of):    Sequentially list conditions, if any, leading to immediate considered events resulting in death) Last   Due to (or as a consequence of):	Death  23d. Date of delivery Month Day Year  art I. 23e. Did tobacco use contribute to the cause of death?
60, cate be executed physician and he burial - transit	by Physician/Medical	Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate Classe Enter Underlytic Course. (Disease or injury that initiated events resulting in death) Last  WUNPENDED  AMENDED  AMENDED  23c. If yes, outcome of pregnancy  1 Yes 2 No 9 V Unknown  Due to (or as a consequence of):	Death  27-10 vt  23d. Date of delivery Month Day Year  rt I. 23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 V Unknown
60, cate be executed physician and he burial - transit	by Physician/Medical	Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate Classe Enter Underlytic Course. (Disease or injury that initiated events resulting in death) Last  WUNPENDED  AMENDED  AMENDED  23c. If yes, outcome of pregnancy  1 Yes 2 No 9 V Unknown  Due to (or as a consequence of):	Death  23d. Date of delivery Month Day Year  art I. 23e. Did tobacco use contribute to the cause of death?
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60, cate be executed physician and he burial - transit	Completed by Physician/Medical	Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a	Death  23d. Date of delivery Month Day Year  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown  24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No
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Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical Certification: To Be Completed by Physician/Medical	Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Set For Underly Cours (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence	Death  23d. Date of delivery Month Day Year  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown  24a. Was an autopsy performed? 1 Yes 2 No 2 No 3 Probably 4 Unknown  24a. Was an autopsy performed? 1 Yes 2 No 6 No 6 No 6 No 6 No 6 No 6 No 6 No

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2010 Doral Jean Swan August 10:36 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Months Hours (Month, Day, Year) 117 1 1924 Illinois 358-12-4469 86 Director Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🙀 No MD Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 5627 Bradley Boulevard 20814 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14, Race - American Indian. Armed Forces?
1 ☐ Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White "natural", 3 X Widowed 4 □ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed wit. Department of Health and Mental Hygier Important: If item 27 is marked other t. any injury or other traumatic event, the once. Health Care Registered Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Nussle John H. Laura Haug 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 08260 Pamela S. Swan, daughter 3009 Lake Avenue Wildwood. New Jersey 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Metro Crematory, Inc. 08/10/10 4 Donation 5 Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation Society of MD, George MacNabb 299 Frederick Road Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 48 hrs Immediate Cause (Final Physician/ Sepsis disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of) ng physician and as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Year Month Day Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Gasterointestinal bleeding 2 No 3 ☐ Probably 4 ☐ Unknown . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy this certificate has death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical vision of Vital 26. Place of Death (Check only one) examiner? Hospital 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural
Accident
Suio injury 5 Pendina Investigation 24 hours after death Funeral Director. 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Name Praction or 15th of my hard of the cause of the caus 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) D0062435 August 10, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

Sayed Eisayyad, M.D.

2. Registrar's Sig

10110 Molecular Drive Rockville, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death Decedent's Name (First, Middle, Last) Month **Physician** 2010 /Medical 4b. City. Town, or Location of Death 4c. County of Death Eacility Name (If not institution, ive street and number) **Examiner** Baltimore Catonsville If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Feb 21, 1916 Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 □ M 2 1 F 94 Yrs Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 No Directo Gwynn Oak Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code **USA** 21207 1140 St. Agnes Lane Funeral Was Decedent of Hispanic Origin? (Specity Yes or NoIf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White <u>ک</u> 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16b Kind of Business/Industry Westinghouse 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dept Of Defence Accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florence L. Armiger Leroy H. Smink 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1140 St. Agnes Lane Gwynn Oak, Maryland 21207 Deborah Heinritz, Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐Removal from State Loudon Park Cemetery 08/13/10 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, Maryland 21228 21. Signature of Funeral Service Licensee Thomas Gregor Momas 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Mombolis cordson Physician Medical Due to (or as a consequence of): xaminer Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical as attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 ☐ Other (specify) detached 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pe 1 Yes 2 No 3 Probably 4 No Nown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1∐ Yes 2 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one funeral director. Other: 4 Stursing Home 5 Residence 6 Other (Specify) Hospital: 3□ DOA 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient Certification: To After this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28h Time of 28c. Injury at Work? Hospital or Attending 5 ☐ Pending investigation 1 ⊠Natural 1 ☐ Yes 2 ☐ No M 24 hours after death. 2 ☐ Accident filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 ☐ Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier within 24 hor To the Fune completely fi (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 10 D47683

DHMH 17 Rev 1/2001

State

Registrar

Some

203

Balhore

21209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835

South

Ave

More

led (Month, Day, Year)

AUG 1220

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 20 10 25253 10-05981 State of Maryland / Department of Health and Mental Hygiene Jason John Schostag 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day August 9, 2010 0735 hrs **Medical Examiner** <u>Jason John Schostag</u> 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Glen Burnie Baltimore Washington Medical Center 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 5. Social Security Number **Funeral** Months Davs Hours Director Country) MD July 19, 1977 1 X M 2 F 33 217-13-0861 Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 Yes 2 X No more, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Memtal Hygene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once. Glen Burnie Anne Arundel Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21060 U.S.A. 317 Shannon Forest Court Funeral 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married Yes If Yes, Give Year or Dates: White 1 Yes 2 X No specify: Specify. 3 Widowed 4 X Divorced þ 16a, Decedent's Usual Dccupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Construction Pipe Fitter Com 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gladys M. Hugo Gerald A. Schostag 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဥ Glen Burnie, MD 21060 317 Shannon Forest Court Mr. Gerald A. Schostag Father 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State Date 20a. Method of Disposition Baltimore, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State August 14 c Crematory 2010 Glen Burnie, MD

22. Name and Address of Facility Singleton Funeral & Cremation Important: Atlantic Crematory Donation 5 Other Specify þ 21 Sonature of Funeral Service Licenses Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 M01220 Approximate Interval Part I. Entel the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line Modica Death Cocaine and Methadone Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): an/Medical X UNPENDED AMENDED 27-28a-f.perME.G907.9/22/2010.WS #23a 27-28
23c. If yes, outcome of pregnancy 23d. Date of delivery IF FEMALE: 23b. Was decedent pregnant in the Year Live birth 3 Ectopic pregnancy Month Day Fetal death past 12 months?

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deached for use as the burial - transit

Physic	1 Yes 2 No 9 Unknown	9 Unknown				
ē	Part II. Other significant conditions	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown			
ompleted			24a. Was an autopsy performed?  1 V Yes 2 No 1 Proceed No 24b. Were autopsy findings available prior to completion of cause of death?			
C	25. Was case referred to medical	26.Place of Death (Check of	only one)			
o B	examiner? 1 ✓ Yes 2 No	spital: 1 Inpatient 2 🗹 ER/Outpatient 3 DOA Other Nursin	sing Home 5 Residence 6 Other:			
	27. Manner of Death	(Handle Davidson)	28d. Describe how injury occurred			
Certification	1 Natural 5 Pending 2 Accident Investigation	Fnd:   rnd:   1   Yes 2   X   No	unknown			
tific	3 Suicide 6 X Could not be	28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State) 317 Shannon Forest			
ě	4 Homicide determined	(Specify) residence	Court. Glen Burnie. Maryland			
		n: To the best of my knowledge, death occurred at the time, date and place, and				
lical	one) 2 Medical Examiner:	On the basis of examination and/or investigation, in my opinion, death occurred a	at the time, date and place, and due to the cause(s)			

Russell Alexander MD. Assistant Medical Examiner

State 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifie

1. parket

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

August 10, 2010

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

			For State Registrar		State of N	larylari	Cer	tificate of L	neaim ai Death	na ivientai H	ygier Reg.	1e <sub>2</sub> 01	0	25264
	Physicia Medic		1. Decedent's Nan Kathryn	ne (First, Middle	B.			Scrug	gs	2. Date of I Month August		Day 2010 Yes	ar	3. Time of Death 02:08 P M
đ	Examin				, give street and number)			4b. City, Town, or		Death		4c. County of D		1.1
	Funeral	i i	Tate  5. Social Security N	Hospic		ge (In yrs. la	ast birthday)	Linthi If Under 1 Year	.cum If Under 24	Hrs. 8. Date of E	Birth	Anne A	Dirthol	ooo /State or Fernier
	Director		216-32-28 Usual Residence o	368	1 □ M 2 🛣 F		73 Yrs.	Months Days		May 3	Day, 1 <sup>Y</sup> 9	37	Countr	MD
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336	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fur	11. Marital Status 1 ☐ Never Mar 3 ☐ Widowed	ried 2 🛛 Man	12. Was Decedent Armed Forces			Vas Decedent of H Yes, specify Cuba		n? (Specify Yes or N Puerto Rican, etc.)	0-	14. Race - A Black, W Specify: Wh	hite, et	tc.
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Maryland	should and N is ma rauma		19a. Informant's N	ame/Relationsh	nip (Type, Print)					or Rural Route Num			Zip Cc	nde)
	and 2 Health tem 27		Mr. Eric 20a. Method of Dis		tt/ Grandsor	_		Cecil Dr	ive C	Chester, N	_	Location - City	au Tau	Ct-t-
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Baltimore,	permit. F Departm Importal any injul once.		21. Signature of Fu		1 1	ICO	. / 22	. Name and Addres	ss of Facility	1 2nd Ave	S	Glen	ur	nie, MD
		1	Juan	H the	wyles MC	1092	•					emation	Se	rvices, PA.
	Physician/ Medical	6 6	23a. Part 1. Enter shock, or hea Immediate Cause disease or condition resulting in death)	art failure. List c (Final	complications that cause only one cause on each ling.  a.  Due to (or as	e.	hye	r the mode of dying	1.	rdiac or respiratory	arrest,	i	-1 1	Approximate Interval Between Onset and Death
-	Examiner		Convention list or		Due to (or as	a consequ	erice oi).		1:					
	d sit	Examiner	Sequentially list co if any local get cause. Enter Unde Cause (Disease or	erlying	Diwi to (or as	а попялони	ence of):						3	
	kecute and al-trans	Exar	that initiated event resulting in death)	is .	c. Due to (or as	a consequ	ence of):						+	
00	cate be executed physician and the burial-transit	<b>Nedical</b>		ļ	d									
8760	rtificat ing ph e as th	Mec	IF FEMALE:											
. Box 68	Attending Physician: The law requires that the death certificate be executed or death.  ector. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/N	23b. Was decedent in the past 12 1  Yes 2 9  Unknown	months?	23c. If yes, outcome 1  Live Birth 4  Pregnant	2 Fetal	death 3	Ectopic pregnanc Other (specify)	у			23d. Date of Month		y Day Year
P.O.	es that t signed b be deta	اج	Part II. Other signi	ficant conditio	ns contributing to death	out not resu	ulting in the un	nderlying cause giv	en in Part I.					cause of death?
rds,	require been signal	eted								1	Yes	2 5 No 3 □	Proba	ably 4 Unknown
Division of Vital Records,	: The law r cate has b page 2 sh	Completed									s an opsy formed?	prior t	o com	sy findings available pletion of cause of
E	sician: The certificate I rector, pag	Be Co	25. Was case referr	ed to medical				26. Pla	ace of Death /		2 1			<b>5</b> 410
Vita	hysician: lis certific	P B	examiner?	No	Hospital: 1 ☐ Inpat	ient 2 🗆 E	ER/Outpatien	Othe	r:	ing Home 5 🗆 Re	sidence	6 √ Other (Sp	ecify)	realt and of
n of	ding Ph h. After th funeral	ate:	27. Manner of Deat 1—Natural	5 Pendin			28b. Time of injury	28c. Injury work	?	28d. Describe	how inj	ury occurred		G
Siol	Attendar death	Certificate:	2 Accident 3 Suicide 4 Homicide	Investig 6  Could r determ	not be 28e. Place of Inj	ury - At hor	me, farm, stre	M 1 □	Yes 2 No		(Street a	and Number or I	Rural R	Noute Number.
Divi	ital or irs afte al Dire		4 - Homicide	determ	building, et	c. (Specify)				City or To				
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completed filled in by the	Medical	(Check 2	🛚 🖳 Medical E	Physician: To the best of xaminer: On the basis of Nurse Practioner: To the	examination	and/or investi	gation, in my opinio	n, death occur	rred at the time, date	and place	ce, and due to th	e caus	e(s) and manner stated.
	To the Com	_ [	29b. Signature and	title of certifier	M		,	29c, License	number	77	29d. [	Pate signed (Mo.	nth, Da	iy, Year)
			30 Name and addr	ess of person v	vho completed cause of o	leath (Item	23a) (Type, Pr	int)	~ . /	0 0 1	1 ,	1711	_/	1010
			31. Date filed (Mont	The Day Year	32. Registr	m0	305	Hos	2) Jest	Uk me	70	1 Palley	nh	1.2/06/
	Stat Registra		S Bate filed (MONE	AUG 1	2 2010 32. Registr	ar's Signatu	A. A	Dark	7					/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25265 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month ∂ & Physician/ Year CANI ORIS OG TUAM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 1211 Ripple Court Pasadena Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 F Days Hours Maryland Director 220-09-4079 88 August ,1921 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1211 Ripple Court 21122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3

▼ Widowed 4 □ Divorced Specify: Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Assembly Westinghouse 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Victor Phe1ps Llewellyn Little 19a. Informant's Name/Relationship (Type, Print) Daughter Mrs. Doris Allaine Green 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1211 Ripple Court, Pasadena, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Auguste 13, 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Park 2010 Elkridge, Maryland 21. Signature of Fun Succe License 22. Name and Address of Facility 1 2nd Ave., SW Glen Burnie, MD MO1580 21061 Singleton Funeral & Cremation Servies, PA. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset adulath Immediate Cause (Final Ph sician/ Medical resulting in death) Due to (or as a consequer ce of) Examiner Seque itally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Yes 2 No 9 Unknown Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy CAD performed Yes 25. Was case referred to medical Be 26. Place of Death (Check only one 1 🗌 Yes 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier 21438

Registrar

State

31. Date filed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

32. Regist

			1 - State Registrar	Otate of Mid	ii yiaiio				Death			Reg. No.	2010	25266
	Physicia	an	1. Decedent's Name (First, Middle, Last,	)							Date of Dea Month	Day	y Year	3. Time of Death
	/Medic		Peninah Morrison		mith						ugust	7	2010	8:25 A M
	Examin	er	4a. Facility Name (If not institution, give				4b. City		Location			4c.	County of Deat	
w.			11338 Dublin Road 5. Social Security Number 6. Sec		(In uro h	st birthday)	If Unde	r 1 Year	oodsk If Under		. Date of Birt	h	Freder	LCK hplace (State or Foreign
I	Funeral Director		220-28-2763	]M 2⊠F	78		Months		Hours	Min.	eb. 2	v. Year)	l Co	aryland
	yland now		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits
	e Mar	ctor	Maryland Fre	derick		<u></u>	Woods	sboro	)					1 ☐ Yes 2 X No
	vith th	Funeral Director	10e. Street and Number				10f. Zi	p Code	2179	20		10g. Cit	izen of What Co	untry?
	sath v	eral	11338 Dublin Rd	12. Was Decedent E	ver in IIS	13 \	Nas Dece	edent of Hi			ifv Yes or No		14. Race - Ame	
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Event are must be notified at once.	by Fun	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1  Yes 2  N  If Yes, Give  Year or Dates:				ecify Cuba 2⊠No			ify Yes or No- can, etc.)		Black, White	
200-	2 hour		15. Decedent's Edu	cation		16a. Dece	dent's Usu	ual Occup	ation	at of working		16b. K	ind of Business/	
<u> </u>	ithin 7 ne. nan "n	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5-	F)	life. I				st of working			Ja 4 20	
7 7	lled w Tygier ther th	S	12 17. Father's Name (First, Middle, Last)				Ian	n wif		er's Name (	First, Middle,	Maiden	dairy	
	d be fi	Be c	Harry McNair						TO. WIOUT		Baumo			
<u></u>	should nd Me mark imatk	To	19a. Informant's Name/Relationship (7)	rpe. Print)		19b. Mailir	ng Addres	s (Street	and Numb				or Town, State,	Zip Code)
2	nd 2 saith ar		Donald P. Smith/h					olin	_				, MD 21	
บั	sta of Hea item othe		20a. Method of Disposition		20b. Pla	ace of Dispo metery, cren	sition (Na	me of other plac	e)	Da	te	20c. Lo	ocation - City or	Town, State
	Page ment a ant: If ury or		1 XBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)			thaver	n Mem	. Gar	rd.	8/10/			ederick,	
Dalling	permit. Depart Import any Inj once.		21 Signature of Funeral Service Licens	Harbler					ss of Facili n St.				ral Hom MD 2179	
	Physician /Medical Examiner	3	23a. Part1. Enter the disease, or compi shook, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ications that caused ne cause on each lin  a  Due to (or as a pue to (or a) pue	e. S4 a conseque	ence of):	ter the mo	ode of dyin	ig, such as	s cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death
00100	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	edical Examiner	Cause (Disease or Injury that initiated events c. Due to (or as a consequence of):											
.O. DOX	ding Physician: The law requires that the death cert. After this certificate has been signed by the attendinfuneral director, page 2 should be detached for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Mo 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🗆 Fetal	death 3	☐Ectopic ☐Other (\$	pregnanc specify)	у				23d. Date of de Month	livery Day Year
us, r	uires that signed t	by	Part II. Other significant conditions co	ntributing to death bu	it not resul	Iting in the u	nderlying	cause giv	en in Part	I.	23e. Did t			o the cause of death? robably 4 🗌 Unknown
records,	ne law req has beer ge 2 shou	Completed									24a. Was autop		24b. Were a prior to death?	utopsy findings available completion of cause of
N I G	ificate or, pa		25. Was case referred to medical	***					26 Plan	o of Dooth	1 ☐ Yes (Check only o		1 □Yes	s 2□No
>	/sicia s cert directe	To Be	examiner?	Hospital:	nt 2 $\square$ E	ER/Outpatie	nt 3 □ E	Oth	OF:		- ^		6 ☐ Other (Spe	ecify)
	iding Phy th. After thi funeral o		27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Day		28b. Time o Injury		28c. Injur Worl		28	3d. Describe			
DIVISION	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc.	iry - At hor :. (Specify	me, farm, str	reet, facto	ry, office		28	3f. Location ( City or To			ural Route Number,
	e Hospit 124 hours e Funera eletely fille	edical (		rsician: To the best of Iner: On the basis of and manner sta	examinat									
	To th withir To th comp	Me	29b. Signature and title of certifier	11.			25	9c. Licens	e number				ate signed (Mon	
			1 / Seul	be w)					D310	58			8-9-1	0
	5		30. Name and ddress of person who c	ompleted cause of d				nino 1	Бđ	TATO	odehor	. v	∕D 21798	<b>?</b>
	Sta	te	Gene Ashe 31. Date filed (Month, Day, Year)	3. Registra		00 Cor	peri	THE I	nu.	WO	TOTICOL	U, I	ערו א עוי	)
	Registr		AUG 1 2 2010	Constant	1 1		A COLOR							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 25267 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year **2010** DANNY WAYNE SALYERS SR. 07 06:39A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SOUTHERN MARYLAND HOSPITAL CENTER PRINCE GEORGE CLINTON If Unde 9. Birthplace (State or Foreign Country) VIRGINIA 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** Months Hours Min 02-23-1953 1 **X** M 2 □ F Director Yrs <u>230-76-9835</u> Usual Residence of Decedent shov 10a. State 10b. County within 72 hours after death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No VIRGINIA STAFFORD STAFFORD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral FOXWOOD DRIVE 22504 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify. Specify: WHITE Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n: any injury or other traumatic event, the Medic once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) TRUCK DRIVER TRANSPORTATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ ALBERT SALYERS MABEL MEAD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LINDA WEBSTER - SISTER 148 HEMINGWAY PLACE, GEORGETOWN KY 40324 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07-26-10 FAIRFAX, VIRGINIA FAIRFAX MEMORIAL PARK 21. Signature of Funeral Pervice Licent 22. Name and Address of Facility MOUNTCASTLE FUNERAL HOME, 4143 DALE BLVD DALE CITY 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Myocardial Immediate Cause (Final NS) INC Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Year Pregnant at time of death signed by the a d be detached f 2 No Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ has been signed by Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy s certificate ha lirector, page 2 performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No hin 24 hours after death.

the Funeral Director: After this certific

mpleted filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) 1 Yes Hospital 2 🗌 No Other: မ 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 FR/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check

within 2

To the F

complet

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month. Day, Year) 126/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For Amend Item 25 State of Maryland / Department of Health and Mental Hygiene Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 38 Physician/ 031 2010 Medical 4c. County of Death

Baltimore 4a. Facility Name (if not institution, **Examiner** Randallstown 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Birthpic Country) MA Funeral 1 □ M 2 🗓 F Min 04/14/1933 Director 014-24-6121 77 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural" any injury or other traumatic events. 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 ☐ Yes 2 💢 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1500 BEDFORD AVENUE, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 X Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) OWNER SECOND HAND SHOPS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ MORRIS SOSNA ANNA ROSENTHAL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1015 GLENEAGLE COURT, ELDERSBURG, MONA FREEDMAN / DAUGHTER MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW 8/11/2010 REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS. . Signature of Funeral Service Licensee Matt 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final andiovascular Discose Physician. disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and the attending physician and hed for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical CERT IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year funeral director, page 2 should be detached 1 ☐ Yes 2 ☑ 9 ☐ Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Yes 2 No Hospital 1 Inpatient 2 ER/Outpatient 3 IDOA |은 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) ture and title of ce Sig 2010

State Registrar DHMH 17 Rev 7/2009 ame and a

ames 31. Date filed (Month,-Da) Northwest Hospital, 5401 old Coort Rd. Randalktown, MO 21133

of death (Item 23a) (Type, Print)

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MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Aug <eleste Shildt ILID AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Howard County General Columbi 6. Sex If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🗓 F (Month, Day, ug. 8 Months Min Country) Maryland Director 216-12-2010 88 Usual Residence of Decedent 28a-f show 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10d. Inside City Limits **Funeral Director** 1 ☐ Yes 2 🖾 No MD Baltimore Catonsville 10e, Street and Numbe 10f, Zip Code 10g. Citizen of What Country? 403 Neepier Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 ₺ Widowed 4 □ Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Line Worker Maryland Cup Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Williams Katherine Figgs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy Keelan Niece 9704 Finch Court; Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Meadowridge Mem.Park 8/14/2010 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc 1630 Edmondson Avenue; Catonsville MD 21228 21. Signature of Funeral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Lactic Ph\_sician/ Budosi disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine that initiated events resulting in death) Last Due to (or as a consequence of) cian/Medical attending p 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year g Unknown t II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No certificate has tirector, page 2 s 2 - No 1 Yes Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes Hospital: Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred

Box 68760 Division of Vital Records, P.O.

Certific

Medical

Hospital or Attending Physician: The law requires that the death certificate be eral Director: After filled in by the funer within 24 hours a
To the Funeral I
completed filled

1 ☐ Yes 2 g ☐ Unknow
Part II. Other sign
25. Was case refe examiner? 1  Yes 2
27. Manner of Dea

3 Suicide 4 Homicide

29a. Certifier only one)

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Myidian 31. Date filed (Month, Day, Year).

5 Pending

of certifier

Investigation

determined

Could not be

10710

MY

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D42892

#310

29c. License number

Drive

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Columb

2010

210 44

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Aŭgust 2010 9:00 P. M Gerhardt William Strohsacker Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Brighton Gardens of Towson Baltimore 9. Birthplace (State or Foreign Country) Pennsylvania 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Date of Day, (Month, Day, 23 **Funeral** Hours 1 XM 2 □ F 213-24-1850 Director 80 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1

Yes 2 □ No Baltimore Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21212 U.S.A. 106 Taplow Road າ "natural", or item ledical Examiner ກ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced White Year or Dates 1951-54 the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 5+ years Communications Management 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emma Berta Holzwarth Gustav Konrad Strohsacker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (wife) Baltimore, Maryland 21212 Genevieve O'Donnell 106 Taplow Road Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 8-12-10 Baltimore, Maryland <sup>22. Name and Address of Facility</sup> Mitchell-Wiedefeld Funeral Home, 6500 York Road Baltimore, Maryl Signature of Funeral Service Licensee 23a. Part 1. Euler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final DEMENTIN Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 4 Years PARKINSONS if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death ed by the a 1 ☐ Yes 2 L 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by the performance of the signal of t 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, HYPER TENSION 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available ATRIAL FIBRILLATION 24a, Was an prior to completion of cause of death? autopsy 1 ☐ Yes 2 ☐ No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ASS 375.0 1 Tes 2 | No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred LIVING FACILITY 28c. Injury at Certificate: (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical 1 🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 8/11 10005229 malhy amus 2010 mis 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7141 Security Blvd. Baltimore, MD Sindu James, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 2 201 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / I  - State Registrar  State of Maryland / I  - Registrar	Department of Health and Monager of Certificate of Death	8/12/2018 Reg. N	10 25271
	Physici	an	1. Decedent's Name (First, Middle, Last)	bley	Date of Death     Month Day	3. Time of Death
1	/Medic	al	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	07 17 4c. Count	2010 9-27 AM
	Examin Funeral Director		Forestville Health & Rehab  5. Social Security Number   6. Sex   7. Age (In yrs. last bit)	Forestville		nce Georges  9. Birthplace (State or Foreign Country) UNIX
			Usual Residence of Decedent			10d. Inside City Limits
	larylan show	ō	10a. State   10b. County   10c. City, Tow   MD   Prince Georges   Fores	stville		1 ☐ Yes 2 ☒ No
	with the N 3a or 28a-1	Funeral Director	10e. Street and Number 7420 Marlboro Pike	10f. Zip Code 20747	10g. Citizen of USA	What Country?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Andical Expr. inner inset by neithfield an once.		11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S.  Armed Forces 2 unk  1 □ Yes 2 □ No  If Yes, Give  Year or Dates:	13. Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto	Rican, etc.) Bla	ce - American Indian, ack, White, etc. fy: black
1215-0036	within 72 ho ene. than "natur iv "molcal	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+) unk	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ng 16b. Kind of E	Business/Industry
land 21	ild be filed v fental Hygid rked other itc event, tt	To Be Co	17. Father's Name (First, Middle, Last) unk	18. Mother's Name	(First, Middle, Maiden Surna	<sub>me</sub> unk
, Maryland	and 2 shou salth and N n 27 is mar er traumat		19a. Informant's Name/Relationship (Type. Print)  Forestville Health & Rehab	o. Mailing Address (Street and Number or Run 7420 Marlboro Pike,	Forestville, M	Maryland 20747
Baltimore,	Pages 1 ament of He ant: If item ury or oth		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☑ Other (Specify) in state	of Disposition (Name of pry, crematory or other place)	Date 20c. Location	- City or Town, State
Balt	permit. Departi Import any Inj		21. Signal he of Funeral Service Licensee Wade, Director	22. Name and Address of Facility Sta 655 W. Baltimore	Street; Baltin	more, MD 21201
	icate be executed /Medical Examiner the burial-transit	l Examiner	Sequentially list conditions,	riva  on: Cancer  on: Immun Deficience		Approximate Interval Between Onset and Death
.O. Box 68760,	ath certif tttending or use as	Physician/Medical	d	n 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		late of delivery Month Day Year
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al Records,	ician: The law requir certificate has been s ector, page 2 should	Completed			autopsy performed? 1 □ Yes 2 <b>X</b> No	. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
of Vital	ysician: is certific director,	Be c	25. Was case referred to medical examiner?  1 ☐ Yes 2 X No  Hospital: 1 ☐ Inpatient 2 ☐ ER/O		h <i>(Check only one)</i> ome 5 ☐ Residence 6 ☐ O	ther (Specify)
on of	ding Phys h. After this funeral di	tion: To	27. Manner of Death 1. Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b.		28d. Describe how injury occu	
Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fix building, etc. (Specify)		28f. Location (Street and Nun City or Town, State)	nber or Rural Route Number,
	ne Hospit: n 24 hours ne Funera	Medical C	29a. Certifier (Check only one)  1  CertifyIng Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination a and manner stated.	le, death occurred at the time, date and place, nd/or investigation, in my opinion, death occur	and due to the cause(s) and a red at the time, date and place	manner as stated. e, and due to the cause(s)
	To the within To the comp	Me	29b. Signature ant/little of certifier	29c. License number		ned (Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a)  Bahram Pishdad, MD, 1328 Southern	(Type, Print)		
	Sta	te	31 Date filed (Month Day Year) 32 Registrar's Signature		.,	
	Registr		AUG 12 2000 Steven &	Sale		

Physicia Medic Examin

Funeral Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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	Ex	arr	nin	er
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed	within 24 floats are locatil.  To the Funeral Director: After this certificate has been signed by the attending physician and	completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	

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•	<ul><li>State Registrar</li></ul>					tificate o				eg. No.	1 0	
n/ al	1. Decedent's Name David	(First, Middle W .	e, Last)	Ste	evens				2. Date of Death Month Day Year August 6, 2010			3. Time of Death
er	4a. Facility Name (if 1785 Broo		, give street and number Road	er)		4b. City, Town, or Location of Death Dundalk				4c. Cour	nty of Death <b>ti</b> mor	1
	5. Social Security Nu 212-42-2	2495	6. Sex 1 🔀 M 2 ☐ F	7. Age (In yrs. last birthday) 66 Yrs. If Under 1 Year   If Under 24 Hrs.   8. Date of Birth (Month), Days   Hours   Min.   (Month), Day   12-18-1						Year)	hplace (State or Foreign Intry) t Virginia	
tor	Usual Residence of 10a. State	10b. County	_	10c. Cit	10c. City, Town or Location							10d. Inside City Limits
Completed by Funeral Director	MD		ltimore					unda				1 Yes 2 X No
ra	10e. Street and Num 1785 Br		w Road			10f. Zip Cod	21222			10g. Citizen o		
nue	11. Marital Status	OURVIE	12. Was Decede	ent Ever in U.S	s. I13. V	Was Decedent of		(Specify	v Yes or No-		ed Sta	aces ican Indian,
by F	1 Never Marri	ed 2 XMar	ried Armed Force	es?			f Hispanic Origin? uban, Mexican, Pu	uerto Ric	an, etc.)	8	lack, White	
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Be	17. Father's Name (F	-	_ast)		10	IICC OI		Name (F	First, Middle, N			
욘	Willi	am Ste	vens				Rosa	lie	Philli	ps		
	19a. Informant's Na Mrs. Jan			ife)	19b. Mailir 178	ng Address (Stre 5 Brook	et and Number or view Roa	Rural R	oute Number, Junda1k	City or Town	, State, Zip $71$ and	Code) 21222
	20a. Method of Disp	osition				sition (Name of		Date	e	20c. Locatio	n - City or	Town, State
	1 Donation		3 ☐ Removal from S Specify)	Hil.	emetery, crer ltop S	natory or other p ervice	Corp. 8	/11/	2010	Tows	on, Ma	aryland
	21. Signature Teur	neral Service L	icensee)	a	7 13	Name and Aduction 1922 Wisc	dress of Facility K. Funera P. Avenue	1 Ho	me of	Dunda] Md. 2]	k 22	nc.
	23a. Part 1. Enter the shock, or hear Immediate Cause (I disease or condition	t failure. List o Final	complications that cal only one cause on each	used the deat	h. Do not ent	er the mode of c	ying, such as card	diac or re	espiratory arre	st,		Approximate Interval Between Onset and Death
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Medical Certificate: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 n 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?		rth 2 ☐ Feta int at time of d	aldeath 3	Ectopic pregn Other (specify					Date of deli Month	ivery Day <b>Y</b> ear
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Be	25. Was case referred examiner?	ed to medical	Hospital:			1	Place of Death (C					
ate: To	27. Manner of Death	5 Pendir	28a. Date of (Month,	patient 2 injury <i>Day, Year)</i>	28b. Time of injury	nt 3 □ DOA □ 28c, Ir	4 □ Nursin jury at ork? □ Yes 2 □ No	280	d. Describe ho			fy)
Certifi	2	Investi 6  Could determ	not be 28e. Place of	lnjury - At ho , etc. <i>(Specify</i>	ome, farm, str	eet, factory, offic		_	f. Location (St City or Towr		nber or Run	al Route Number,
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			who completed cause				ene st	E	authin	ncre	mo	21001.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician 0200 AM Baby Boy Singh 2010 Theust 6 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Adventist Montgomer Grove Rock Hospita UDOODN 9. Birthplace (State br Foreign Country) Maryland 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, **Funeral** Aug 6, INFANT **Director** Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County show notified at Rockville 1 ☐ Yes 2 No Montgomery Director 7 is marked other than "natural", or items 23a or 28a-f traumatic event, the Medical Examiner must be notifie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20871 **USA** 12108 Sassafras Way Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🔀 No Specify ş 3 ☐ Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) INFANT INFANT INFANT INFANT permit. Pages 1 and 2 should be filed Department of Health and Mental Hygic Important; If item 27 is marked other any injury or other trainmant. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Padamjeet Signah Agnieszka Signah 2 Boy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12108 Sassafras Way; Clarksburg, Maryland 20871 Agnieszka Signah - mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Sta 5 Homy (Specify) in state 4 □ Donation 22. Name and Address of Facility State Anatomy Board 21. Sig at ur of Funeral Privice Licent /irector 655 W. Baltimore Street; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part shock Immediate Cause (Final disease or condition resulting in death) prematurity **Physician** extreme /Medical Due to (or as a consequence of) Examiner membranes oreterm Cu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ore term Con Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 No 24a. Was an autopsy performed? res 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the ft. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D59166 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville MD 20850 Medical Ctr. Dr 9901 MD brect

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1 - State of Mar State of Mar Registrar	yland / Department of Certificate of	Health and Mental Hyg	
	Decedent's Name (First, Middle, Last)	30,11,70410 07	2. Date of Deat	h 3. Time of Death
Physician/ Medical	Vivian <sub>E.</sub> Striegel		Month August	8 2010 2:00 A M
Examiner	4a. Facility Name (if not institution, give street and number) 601 Southgate Road		or Location of Death	4c. County of Death
Funeral	5. Social Security Number 6. Sex 7. Age (I	Aberdee n yrs. last birthday) If Under 1 Year	If Under 24 Hrs. 8. Date of Birth	Harford  9. Birthplace (State or Foreign
Director	213-10-2131	91 Yrs. Months Days	Hours Min. (Month, Day, April 11	Year) Country)
Do tie	Usual Residence of Decedent  10a, State 10b. County 1	Oc. City, Town or Location		10d. Inside City Limits
arylar a-f st fified a	Maryland Harford	Aberdeen		1 Ty Yes 2 No
or 28 e not	10e. Street and Number	10f. Zip Code	1	Og. Citizen of What Country?
s 23a sust b	601 Southgate Road	21001	lt	JSA
Nore, Maryland 21215-0036 ge 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 Ⅸ Widowed 4 □ Divorced  12. Was Decedent Eve Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates.	If Yes, specify Cub	Hispanic Origin? (Specify Yes or No- an, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. SpecifyWhite
15-C	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occu (Give kind of work done life, DO NOT use retired	pation during most of working	16b. Kind of Business Industry
thin 7 than the Merch	Elementary/Seconday (0-12) College (1-4 or 5+)	ife. DO NOT use retired		At Home
d 2 led w led w other ent, t	12 0	Homemaxer	18. Mother's Name (First, Middle, M	
/lan d be fi Aental rrked fric ev	Clarence McFadden		Anna Simmons	,
Baltimore, Maryland 21215-0036 bernit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental hygiene. mportant: If item 27 is marked other than "natural", o ny injury or other traumatic event, the Medical Exam ance.  To Be Completed by	19a. Informant's Name/Relationship <i>(Type, Print)</i> Vivian Pikul / Daughter		and Number or Rural Route Number, te Rd, Aberdee	
Baltimore permit. Page 1 ar Department of H Important: If iter any injury or oth	1 XBurial 2 Cremation 3 Removal from State	20b. Place of Disposition (Name of cemetery, crematory or other pla	(ce) : 0/10 h	20c. Location - City or Town, State  ABERDEENMD
Balt permit. Depart Import any inj once.	21. Signatur in Ineral Service	22. Name and Addr Tarring-Ca 333 S. Par	ess of Facility urgo Funeral Home, ke St, Aberdeen,	P.A. MD 21001
	23a. Part 1. Enter the disease or complications that caused th shock, or heart failure. List only one cause on each line.			
Ph_sician/	Immediate Cause (Final disease or condition	my autus	deseale	Onset and Death
Medical Examiner	resulting in death)  Due to (or as a co	onseque de of):		
ner in the same	Sequentially list conditions, if any, leading to immediate b.	nsequence of):	F 54	
uted ansit	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Apesto News	- Trail me	
ate be executed by sician and the burial-transit sedical Examiner	resulting in death) Last Due to (or as a co	onsequence of);	1	
760 rate be physic the bi	d			
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certificate: To Be Completed by Physician/Medical Exam	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown 23c. If yes, outcome of 1 □ Live Birth 2 □ 4 □ Pregnant at tir	Fetal death 3 Ectopic pregnan	су	23d. Date of delivery Month Day Year
Is, P.O	Part II. Other significant conditions contributing to death but r	not resulting in the underlying cause g	250. 2.0 102	acco use contribute to the cause of death?
/ital Records, P. sician: The law requires the scertificate has been signer lirector, page 2 should be do			24a. Was an autops perform	y prior to completion of cause of death?
tal R cian: The entificate ector, pa	25. Was case referred to medical	26. F	lace of Death (Check only one)	No 1 Yes 2 No
of Vital F Physician: T Physici	examiner? 1 ☐ Yes 2 🛣 No Hospital: 1 ☐ Inpatient	2 ER/Outpatient 3 DOA Oth		nce 6 Other (Specify)
ivision of or Attending Phafter death. Director: After the in by the funeral Certificate:	27. Manner of Death  1 🛣 Natural 5 🗆 Pending (Month, Day, Young) 2 🗀 Accident Investigation			
Division To the Hospital or Attend Within 24 hours after death To the Funeral Director of completed filled in by the filled in by the Medical Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury building, etc. (S	At home, farm, street, factory, office pecify)	28f. Location (Str. City or Town,	eet and Number or Rural Route Number, State)
the Hospita in 24 hours the Funeral hpleted filled	29a. Certiffer (Check only one)  1	ination and/or investigation, in my opini	on, death occurred at the time, date and	place, and due to the cause(s) and manner stated.
To with con	29b. Signature and title of certifier  CV7 GUM (MM)	29c. Licens	25 9 4 6 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	3d. Date signed (Month, Day, Year)
1	30. Name and address of person who completed cause of death	n (Item 23a) (Type, Print)	/   0   1	
Y)	May 25 Jew	> lam Mn	6 WY ME	.78
State Registrar	31. Date filed (Month Day, Year) AUG 12 2010 32. Registrar's	Signature and		
DHMH 17 Rev 7/2009				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ALBERT TAUBER SR. AUGUST 10:30a м P 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 7925 32nd STREET ROSEDALE If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **№** M 2 □ F Hours 03/02/1919 MARYLAND 217-18-5944 Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director BALTIMORE ROSEDALE 1 Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 7925 32nd STREET 21237 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black White, etc. δ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 WHITE 1 Yes 2 No Specify: If Ves Give WW II 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) TRUCK DRIVER NATIONAL BREWERY permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) 2 should be file h and Mental F. 7 is marked ot ည BORNEMAN FRANK TAUBER LENA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32nd STREET BALTIMORE, MD 21237 ALBERT C. TAUBER JR./SON 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗆 Burial 2 🛣 Cremation 3 🗀 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 8/11/10 BALTIMORE, MD METRO CREMATORY 21. Signature of Funeral S vice Li ensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL 21237 CHESACO AVE BALTIMORE, 1211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ mur with disease or condition resulting in death) MULTO Medical Due to (or as a con equence of): Examiner everyory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last physician a Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No the g Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed in page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 No 1 🗌 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify, |으 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No injury 5 Pending Accident Investigation the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State, within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сотрыется 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 2102 8-10-10 wen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21236 Klin 602 State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			for State Registrar	State of Ma	ryianu / Dep <i>Ce</i>	ertificate of		, ,	eg. N2 0 1 0	25276
	Dhysisi		1. Decedent's Name (First, Middle, La	,				Date of Deat     Month		3. Time of Death
	Physicia /Medic		Duane Keith	Tinsley				August	10 201	0 10:55P <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give			1	r Location of Death		4c. County of D	
-+ '	Euparal		Kline Hospic  5. Social Security Number 6. 5		(In yrs. last birthda		Market If Under 24 Hrs.	8. Date of Birth (Month, Day,	Frede:	Birthplace (State or Foreign
t	Funeral Director		212-74-2267	<b>⊠</b> M 2□ F	53 Yrs.	Months Days	Hours Min.	reb. 16	Year)	Country) Missouri
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or I	_ocation				10d. Inside City Limits
	Mary I-f sho	tor	Maryland F	rederick		Frederi	ick			1 ☐ Yes 2 ☐ No
	h the or 28a	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What	Country?
	23a c		4815 TeenBarn	es Road			21703		U.S.	Α.
	tems	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13	. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		merican Indian, /hite, etc.
336	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, the Medical Examinar must be notified at	þ	1 X Never Married 2  Married 3  Widowed 4  Divorced	1 ∐Yes 2 ⊠N If Yes, Give Year or Dates;	0	1 ☐ Yes 2X No	Specify:		Specify:	White
21215-0036	2 hou	Completed	15. Decedent's E. (Specify only highest gr	ducation	16a. Dec	edent's Usual Occup	oation	dia a	16b. Kind of Busine	ess/Industry
2	I within 72 ho giene. r than "natu I're Medice.	nple	Elementary/Secondary (0-12)	College (1-4or 5-	ilife	DO NOT use retire	d)			
12.5	al Hygier other th		12 17. Father's Name (First, Middle, Last		field	d service	specialis		computer	printer
and	e d d d d	Be C	Robert G. Tinsl				Į.	ith Hugh		
Maryland	2 should and Mer is marke	P	19a. Informant's Name/Relationship		19b. Ma	ling Address (Street				te, Zip Code)
	7 is		Robert L. Tinsley			White Tai			KY 4250	
=	8 6 = 3		20a. Method of Disposition			oosition (Name of ematory or other pla			20c. Location - City	
Ĕ	Pages ment of ant; If its lury or o		1 ☐ Burial 2 🙀 Cremation 3 ☐ 4 ☐ Donation $_{\mathbb{A}}$ 5 ☐ Other (Speci		All Cou	nty Crema	tion 8/12		Sykesvil	
Baitimore,	permit. Page Department ( Important; If any injury or once.		21. Signatur, of Funeral Service Lice	ise (		22. Name and Addre			neral Hom ytown, MC	
			23a. Part 1. Enter the disease, or com	plications that caused	the death. Do not e					Approximate
-ija	Physician	1	shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each lin-		ma M	14tifa.	cmo		Interval Between Onset and Death
	/Medical		resulting in death)	a.  Due to (or as a	consequence of):	A. III	1-(-1-1-(-)-1			1 (00/10) 2
	Examiner	_	Sequentially list conditions,	b						
١.	ted nsit	nine	Sequentially list conditions, in any, secure to introduct cause. Enter Underlying Cause (Disease or injury that initiated events	Date to for dela	consequence of):					
P	execuna and ial-tra	Examiner	that initiated events resulting in death) Last	CDue to (or as a	consequence of):					
68/6U	tificate be executed g physician and as the burial-transit	edical		d						
	± 0, ∞		IF FEMALE:							_
X R R	ath ce attendii for use	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	2 Fetal death 3	Ectopic pregnand	СУ		23d. Date of Month	delivery Day Year
5	requires that the death cer seen signed by the attendir hould be detached for use	Physician/N	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of death 5	Other (specify) _				
κ, Τ	ned b		Part II. Other significant conditions	contributing to death bu	t not resulting in the	underlying cause giv	ven in Part I.	23e. Did tot	pacco use contribut	e to the cause of death?
Sol	aw requires that s been signed b s should be deta	ed by						1 □ Ye	es 2 No 3	Probably 4 Dnknown
9	aw as t	plet						24a. Was a	n 24b. Were	e autopsy findings available to completion of cause of
	The ate h	Completed						perforr	ned? deatl	h? Yes 2 No
VItal	Physician: rthis certific ral director, I	Be	25. Was case referred to medical examiner?	Haanitali			26. Place of Deat			, ,
0	Physical direction	<u>۲</u>	1 ☐ Yes 2 🕍 No 27. Manner of Death	Hospital: 1 Inpatier	nt 2 ☐ ER/Outpati		4 □ Nursing Ho		ence 6 🖾 Other (5	Specify) hospice
	Attending r death. ector: After by the funer	Certification:	1 Natural 5 Pending 2 Accident investigatio	(Month, Day	(Year)	Wor	k?  Yes 2□No	Zou. Describe no	ow injury occurred	
	Atter er dea ector by the	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of inju	ry - At home, farm, s	treet, factory, office				r Rural Route Number,
5	tal or rs afte al Dir ed in	Cert	4 Difformede	building, etc	, (орвену)			City or Towr	i, State)	
	To the Hospital or Attendi within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier (Check only one)  Check only 2□ Medical Exa	nysician: To the best of miner: On the basis of and manner stat	examination and/or	ath occurred at the ti investigation, in my	ime, date and place opinion, death occui	, and due to the c rred at the time, d	ause(s) and manne ate and place, and	er as stated. due to the cause(s)
	To the Within To the compl	Me	29b. Signature and title of certifier			29c. Licens	se number	2	9d. Date signed (M	Ionth, Day, Year)
			Pres /2			Do	18104		8/11	12010
	1		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type	e, Print)	0 -			
	\		31. Date filed (Month), Day, Year)	MD, 516	Trail #	tve, tr	ederic	K, MI	) S17	07
	Sta Registra		Alic 10 of		i a Signature	Lill		,		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 252 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician**  $p^{M}$ Taylor 08 10 2010 5:05 Adele /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Middle River 7403 Greenbank Road If Under 1 Year \_\_If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Davs 1 □ M 2 👿 F Months 10/08/1942 MD Director 67 220-38-7112 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Events and any angle. 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h County 1 ☐ Yes 2 ☑ No Director Middle River Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21220 by Funeral 7403 Greenbank Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 12 No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Never Married 2 X Married 1 ☐Yes 2 No Specify Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Social Security Clerk 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stenzel Elizabeth Hahn Sanford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7403 Greenbank Road, Middle River, MD 21220 Ronald J. Taylor, Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/14/2010 | Woodlawn,Maryland Lorraine Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, MD 21214 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) 1/60 (5 **Physician** /Medical ue to be a consequence of) Examiner sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Division of Vital Records, P.O. Box 68760, Physician/Medical attending pt IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part ii, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? has autopsy After this certificate ha funeral director, page nerform# 1 □Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) 1 Tyes Certification: To 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Naturai 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation I Director: A d in by the fi 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (I) 419 5009 Honevao Buildine State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 26 per dr., 9906,08/17/2010dhb

For State Amend Item 26 per verb. 9966,08/12/2010dhb

Amend Item 26 per verb. 9966,08/12/2010dhb Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month August 6 2010 Paula Varga 14:25 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Harford Upper Chesapeake Medical Center Harford County Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours December 29 1921 Szekesfehervar, Hungary **Director** 216 38 4639 88 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Director Maryland Harford Bel Air 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 72 hours after death with 1333 Springvale Drive 21015 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. ð 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Mediconce. (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Beautician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Terez Antal Antal Kovats 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1333 Springvale Drive Bel Air, Maryland 21015 19a. Informant's Name/Relationship (Type, Print) Paula Nyitrai 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkwood Cemetery August 9 2010 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) g turn of Funeral Service Licenses 22. Name and Address of Facility
Lassahn Funeral Home Inc 7401 Belair Road Baltimore Maryland 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line INFARCTION Immediate Cause (Final MYOCARDIAL ACUTE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ISEA-SE NAONAR Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) MELLI DIABETES Cause (Disease or linjury for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) ned by the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown the funeral director, page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by EMENTI 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an this certificate has I autopsy Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 🔲 Yes 은 1 Inpatient 2X ER/Outpatient 3 IDOA 4 Nursing Home Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred After injury 1 Natural 5 Pending Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination aperor investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 To the F only one) 29c. License number 29b. Signature 29d. Date signed (Month, Day, Year) D0015462 09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MIGUEL KARA CUSCHANSKY 200 E. 331d St #640 KARACUSCHANSKY 31. Date filed (Month, Day, Year) **AUG 12 2010** 32. Registrar's Signature State Registrar

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			For State	State o	t Marylan		artment of I <i>tificate of L</i>		and Mental Hy		0010	25279
			Registrar  1. Decedent's Name (First, Middle,	Last)	-	061	uncate of L	Jeaur	2. Date of D			3. Time of Death
	Physicia Medio		HAZEL ELI	ZABETH	WALKI	ΞR			AŬĜŪS	T P	<u> 20 m</u>	11:35а м
	Examin	er	4a. Facility Name (if not institution, STELLA MARIS				4b. City, Town, o	MUIN		I	. County of Dea	ORE
	Funeral Director		5. Social Security Number 217-01-6273  Usual Residence of Decedent	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs. Ia 90	Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. 8. Date of B Min. (Month, D 0 3 / 1 8	irth 192 192	20 PEI	thplace (State or Foreign ountry) NNSYLVANIA
	Maryland 28a-f show notified at	Director	MD BALT	IMORE		, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2X☐ No
	th with the ns 23a or must be	Funeral [	10e. Street and Number 7844 OAKDALI					7			tizen of What Co	
9036	filed within 72 hours after death with the Maryland the Hygiene. A thygiene. A dether than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 🕅 Widowed 4 ☐ Divorced	Armed Fo 1 ☐ Yes If Yes, Giv	1 ☐ Yes 2 XNo			lispanic Origan, Mexican Specify:	gin? (Specify Yes or No n, Puerto Rican, etc.)		14. Race - Ame Black, Whit Specify: WI	
Maryland 21215-0036	vithin 72 hor iene. r than "nat the Medica	Completed	15. Decedent (Specify only highes Elementary/Seconday (0-12) 1 2			(Give life. D	dent's Usual Occup kind of work done o O NOT use retired) OMEMAKE]	during most	t of working		ind of Business N HOMI	
yland 2	should be filed vand Mental Hyg is marked othe aumatic event,	To Be	17. Father's Name (First, Middle, La	*	SE			18. Mothe	er's Name <i>(First, Middle</i> 【RTLE	e, Maiden . E .	Surname) WRI(	ЭНТ
	1 and 2 should be of Health and Ment: item 27 is marker: other traumatic e		19a. Informant's Name/Relationshi			790	ELMHUI		er or Rural Route Numb	MORE	MD 2	21237
=	permit. Page 1 a Department of H Important: If ite any injury or ott		20a. Method of Disposition  1    Burial 2 □ Cremation  4 □ Donation 5 □ Other (Sc	ecify)	State Co	emetery, crer RDENS	sition (Name of natory or other plac OF FAI	rh 8	Date 3/13/10	BAL	ocation - City or $\mathbf{TIMORI}$	E, MD
Ba	permi Depa Impo any it		21. Signature of Figure 21.								LE FUN RE, MI	NERAL HOME 21237
	nysician Medical Examiner	_	23a. Part 1. Enter the disease, or a shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a. CERE	ch line.	ULAR A	ACCIDENT	g, such as	cardiac or respiratory a	irrest,		Approximate Interval Between Onset and Death
	ath certificate be executed attending physician and for use as the burial-transit	ical Examiner	if any, leading to immediate cause. Enter Underrying Cause (Disease or linjury that initiated events resulting in death) Last	с	or as a consequ							
. Box 68760	සු පි	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🕱 No 9 ☐ Unknown	1 Live	come of pregnar Birth 2  Feta nant at time of d	Ideath 3	Ectopic pregnand Other (specify)	су			23d. Date of de Month	livery Day Year
ords, P.O	I ne law requires that the destate has been signed by the apage 2 should be detached	by	Part II. Other significant condition	ns contributing to d	eath but not resu	ulting in the u	nderlying cause gi	ven in Part		Yes 2	<b>X</b> No 3□F	o the cause of death?  Probably 4 Unknown
Reco	Ine law ate has page 2	Completed	25. Was case referred to medical						auto peri 1 Yes	opsy formed? 2X No	prior to death?	completion of cause of
Vita	iysician: is certific director,	To Be	examiner?  1  Yes 2  No	Hospital:	Inpatient 2	ER/Outpatié	oth 3 DOA Oth		th (Check only one) ursing Home 5 🗆 Res	idence 6	T Other (Spec	-ifu) BOCDTCE
Division of Vital Records,	ding Pr h. After th funeral	Certificate: T	27. Manner of Death  1 X Natural 5 Pending 2 Accident Investiga	28a. Date (Montation		28b. Time of injury	28c. Injur work	y at	28d. Describe		-	nity) BUSFIGE
DIVIS	ital or Att urs after di ral Directe lled in by t		3	28e. Place	of Injury - At horning, etc. (Specify)		eet, factory, office			(Street and wn, State)		ral Route Number,
:	Io tre hospital or Atten within 24 hours after deat To the Funeral Director: completed filled in by the	Medical	(Check 2 Medical Exonly one) 3 X Certifying I	aminer: On the bas	is of examination	and/or inves	igation, in my opinio	on, death od e time, date	place, and due to the courred at the time, date and place, and due to t	and place he cause(s	, and due to the s) and manner as	cause(s) and manner state stated.
D	vit Cor		29b. Signature and title of certifier	Will	WP		29c. Licenso	e number	92	29d. Dat	te signed (Mont	h, Day, Year)
_			30. Name and address of person w					ттмо	NTIM. MD 2	1093	,	

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [ for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 145P M Month Day **Physician** Watkins Howard 2010 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner altimore Hanklin Square Hospital center osedale If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Social Security Number . Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) 1**∑** M 2□ F Months Days Hours 68 Yrs. 1942 February 28, **Director** 219-40-3290 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1 ☐ Yes 2 🔀 No Director Culpeper Virginia Culpeper 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 22701 13107 Mount Zion Church Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 → Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2√2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Computer Programmer 12 years 2 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Evelyn Lucille Williams Elmer Vanvert Walkins ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) t: If item 27 Is n y or other traun 3467 McShane Way, Dundalk, Maryland Anne E. Kanour Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date August 11, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any Injury or once. Baltimore Maryland Bayview Crematory 2010 permit. Sign Lure of Funeral Service License 22 Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) **Physician** neymonia /Medical Due to (or as a consequence of): Examiner lung cancel retastasis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of; Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) the 1 ☐Yes 2 ☐No be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has funeral director, page 2 autopsy performed? res 2 TVNo 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{(Specify)} \) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident the within 24 hours after death To the Funeral Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0063974 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Or Imran Side 31. Date filed (Month, Day, Year) Siddigi Square Drive Ballimore Mb. 21237 State AUG 12 2010 Registrar

DHMH 17 Rev 1/2001

Howard

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death AMonth Physician/ 6:45 PM GEORGE ZO(O WINFKID Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ROAD FK60 GRICK STONE PREDBRICK Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 225-46-0236 Min. COUNTRE CONIA Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director FREDBRICK MID FKODGRICK 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral J5 21703 STUNE POND 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No Specify: BLACK Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Meany injury or other traumatic event, the Meany ones. Elementary/Seconday (0-12) College (1-4 or 5+) SAW MILL LABORDR 60 TH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JONES JESSIG WINFIELD ELIZABUTH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STONE RD BERNICE MACK (DAU) FREDERICH MD 20b. Place of Disposition (Name of cametery, crematory or other place)

LITE BOTHO BAD CH Aug 14, 2010 STONEY CREEK VA 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Grenses 22. Name and Address of Facility AYL. ROLLING For Krown C Buyz 110 WEST SOUTH ST RUDGERICK MD 21705-3500 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician SENILE EMENTIA disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of) ate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Tinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed' 1 ☐ Yes 2 ☐ No 2 Yes within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 2 Accident
3 Suicide
4 Homicide Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified DOO 61410 AUG, 09, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOLL HOUSE HE FREDERICK, MD

Registrar
DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

32. Fegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #26 Per PHY C906 8/12/2010 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 22:19 M 2010 August WILLIAM OLIVER WARFIELD 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death HARFORD CO HAVRE DE GRACE HARFORD MEMORIAL HOSPITAL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | MAR . | 22 | 1928 6. Sex 1 XXXI 2 ☐ F Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday) 82 MARYLAND 217-22-1879 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 ☐ Yes XXXNo ABERDEEN MARYLAND HARFORD CO 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21001 618 EDMUND STREET Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 14. Race - American Indian, Black, White, etc 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2XXXo Specify: Specify: BLACK 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HEAVY EQUIPMENT OPERATOR APG 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CHARLES F. WARFIELD unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 820 Windstream Way, Unit B., Edgewood Md., 21040 Deneen Warfield/Daughter 20c. Location - City or Town, State Date 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 Purial 2 ☐ Cremation 3 ☐ Removal from State DARLINGTON, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) BERKLEY CEMETERY 08-14-10 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
WILLIAM C BROWN COMM FUNERAL HOME-HARFORD,
321 S PHILADELPHIA BLVD, ABERDEEN, MD 21001 Approximate Interval Between Onset and Death far 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ACUTE MYOCARPIAL INFARCTION disease or condition resulting in death) Due to (or as a consequence of): CORONARY if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last MELLHUS PIABETES Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PROSTATE CARCINOMA 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown DYSLIPIDEMIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' FRONTAL LOBE IN FAR CT 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No

Physician /Medical Examiner

**Physician** 

Examiner

Funeral

Director

show

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item 27

permit. Pages 1 a Department of He Important: If iten any Injury or oth once.

Director

Funeral

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Completed

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traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Records,

of Vital

Division

H

/Medical

Examine physician and the burial-transi Physician/Medical use as 2 Completed certificate leral director, Be Certification: To To the Hospital or Attending P within 24 hours after death.

To the Funeral Director: After t completely filled in by the funera

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

Other: 4 Nursing Home Statesidence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

29a. Certifier

Medical

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Iren Nowalons po

D08096

29d. Date signed (Month, Day, Year) AUGUST 9, 2610

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANDREW NOWAKOWSKI MD 35 FULFORD AYE. BELAIRMO 24014

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Thelma Willingham 12:55 PM lugust 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Hopkins Bay view Medical Center 8. Date of Birth (Month, Day, Yea March 18, If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🏻 F Months 1928 Maryland Director 216-24-4940 82 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8022 Gough Street 21224 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Š 1 Never Married 2 Married 2 X No 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🔀 No Completed 3 ₺ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Levin A. Woodland Bertha M. Stewart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mitchell Willingham Son 3113 Flickinger Road; Westminster, MD 21158 20a Method of Disposition 20b. Place of Disposition (Name of cernetery, crematory or other place, 20c. Location - City or Town, State 1 🖾 Burial 2 🗌 Cremation 3 🔲 Removal from State Loudon Park Cemetery 8/14/2010 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Licenses 740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between O set and Death Immediate Cause (Final Physician Aspiration Preumonia disease or condition resulting in death) WEEK Medical Due to (or s a consequence of Examiner sophageal Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) 9 Unknown á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed bage 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I autopsy performed? completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 2 1 X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No Natural 5 Pending ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0053627 08.10.10 0 0

Registrar

State

vsevolod

31. Date filed (Month, Day, Year)

5501 Hopkins Bayview Circle, Baltimore, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Polotsky, mD -

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 2010 5:30 P M August Katherine B. Zumbrun Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Future Care Cherrywood Reisterstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day Yea
Feb 20, Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M **XX**F 96 217-09-9879 Director Maryland Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2XXNo Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 807 Suburan Rd. 21136 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc Completed by 1 Never Married 2 Married 1 Yes If Yes, Give XXNo Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify. Specify: White XX Widowed 4 Divorced "natural" Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Retai1 Sales Lady Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental ⊢ marked of ည Ray Frank Smith Barbara Bender and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 P.O. Box 334; Maugansville, MD 21767 permit. Page 1 and 2 Department of Health Robert P. Neisser / Nephew Important: If item any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place to realize Park Cemetery 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State 8/16/10 Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. Signature of Fin ral Se License 11605 Reisterstown Rd. Owings Mills, MD 2111 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Priysician Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (5r as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed detached for use as the burial-tran the attending physician and that initiated events Due to (or as a consequence of). resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months Month Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of nas autopsy performed within 24 hours after death. To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No Yes completed filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 2 No မ 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 🔲 Yes 1 Natural 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Pactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

Registrar
DHMH 17 Rev 7/2009

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State

30. Name and address of pers

31. Date filed (Month, Day, Year)

AUU A

21200

MD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene U 1 U State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month <sup>Day</sup> 2010 July\_ 26 11:54 a <sup>™</sup> Alan L. Anth<u>ony</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Casey House Rockville Montgomery If Under 1 Year 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 6. Sex If Under 24 Hrs. 8. Date of Birth **Funeral** Days 03-19-1939 Months Hours Min. 1 XM 2 🗆 F 71 Yrs. Director 197-30-0974 Usual Residence of Decedent ıral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🛛 Yes 2 🗆 No MD Chevy Chase Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4700 Bradley Blvd, Apt.103 20815 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates. by 1 Never Married 2 X Married 1 Yes 2 X No Specify. "natural" 3 Widowed 4 Divorced Specify: Completed White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Means, injury or other traumatic event, the Means Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Medicine Doctor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Frank Anthony Esther Hoffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rob Anthony, son 4748 N. McCoy Ct., NE, Marietta, GA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery crematory or other place,
Shalom
Memorial Park 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/29/2010 Huntingdon Valley, PA Signatur eral Service Licensee Danzansky-Goldberg Memorial Chapels, 1170 Rockville Pike, Rockville, MD MO1255 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician. Endstage Parkinsons disease or condition Medical resulting in death) **Examiner** Acute and Chronic Respiratory Failure Sequentially list conditions, Examine Due to for as a consequence of: If any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months? Day Month Year Pregnant at time of death Unknown 2 \ No signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4x Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? within 24 hours after death.

• the Funeral Director, After this certificate to completed filled in by the funeral director, page 2 XN 1 Yes 2 🗌 No Yes 25. Was case referred to medica æ 26. Place of Death (Check only one) Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) Hospice မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical

State Registrar 29a. Certifier

(Check

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Nichole Christerson,

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License numbe

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

R120698

CNP, Casey House, Muncaster Mill Road, Rockville, Maryland

July 27, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 2<sup>3</sup>3 20°10 8:30 A M Frances Indiana Abell Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Mervel: Deceased's Residence-23925 Dean Ro Hollywood Mary' 9. Birthplace (State or Foreign 8, Date of Birth **Funeral** Days 1 □ M 2 🕱 F Months Hours (Month, Day, Year) January 19, Country) Director 1914 Maryland 213-82-1242 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20636 23925 Mervell Dean Road USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 🗆 Yes 2 😾 No If Yes Give Specify Specify. 3 X Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 0 Own Home <u>Homemaker</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be filed f Health and Mental H item 27 is marked ot ည Frances Indiana Yates ohn Philip Wilkinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23420\_Hollywood\_Rd.\_Leonardtown,\_MD\_20650 Marjorie Ann Jones / Daughter injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth Date Page 1 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Leonardtown, Maryland 8/2/2010 Charles Memorial Gardens 21. Signature of Funeral Service picense 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. ichaelo P.O. Box 270 Leonardtown, MD 20650 Jardene t 1. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest ck, or heart failure. List only one cycles on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Physician Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of the attending physician and shed for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Vear Pregnant at time of death 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy death? perform After this certificate 1 Yes 2 No Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA funeral Manner of Death 28a. Date of injury (Month, Day, Year) Certificate; 28h Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation after deat 6 Could not be Suicide
Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours a

To the Funeral C Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 7/2009

State

Registrar

29b. Signature and title of certifier

30. Name and address of pe

31. Date filed (Month, Day, Year)

AUG 02

40900 Merchants Lane, Suite 205, Leonardtown, Maryland

on whecompleted cause of death (Item 23a) (Type, Print)

Jennifer Merry Schmidt

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July Mitsuko Kataoka Burton 20ÎÎ 2:45 Рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 18701 Walkers Choice Road, Apt#3 Montgomery Montgomery Village Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days (Month, Day, uly 28 Hours 1 M 2 1x F 213-38-2989 Country) Japan Director 1924 85 July Usual Residence of Decedent show or 28a-f shov be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Maryland Montgomery Montgomery Village 1 Yes 2 XNo 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 20886 United States 18701 Walkers Choice Road, Apt#3 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian Armed Forces?
1 ☐ Yes 2 🖾 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Completed 3 X Widowed 4 Divorced Asian Year or Dates er than "natura , the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) t. Page 1 and 2 should be filed within trent of Health and Mental Hygiens rtant: If item 27 is marked other the njury or other traumatic event, the 12 Supply Manager Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Unknown Sugiura Masao Kataoka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1111 University Blvd. West, #1319A, Silver Spring Maryland 20902 William Burton permit, Page 1 and 2
Department of Health
Important: If item 27
any injury or other to 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State cemetery, crematory or o Metropolitan July Žã, 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 2010 tory . Signature of Funeral Service Licer 22. Name and Address of Facility DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877 Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Cardiac Arrythmia Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Syncopy Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed
24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physician and
eted filled in by the funeral director, page 2 should be detached for use as the buriar-transit Carotid Stenosis that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes Mellitus 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 X No Other: 1 🗌 Yes 욘 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 💹 Natural 5 Pending injury 1 🗌 Yes 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined within 24 hours a

To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number D52457 Mas July 28, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9001 Shady Grove Court, Gaithersburg, MD 20877 Mo-Ping Chow, M.D.,

State

Registrar

31. Date filed (Month, Day, Year)

29

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State RegistraMEND#12perFH,8/6/10,BMW,MbCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 23, Alexander Bloomfield 2010 3:15 P M Medical City, Town, or Location of Death Bethesda 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Suburban Hospital Montgomery 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 X M 2 🗆 F 101 Months Hours Min. 06/08/1909 Poland **Director** <u>083-36-1805</u> Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City. Town or Location filed within 72 hours after death with the Maryland al Hygiene. Director Bethesda 1 Yes 2 □ No MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5215 West Cedar Lane 20814 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. δ 1 Never Married 2 Married 1 XYes 2 X Yes If Yes, Give 4-29 Year or Dates 5-1 Baltimore, Maryland 21215-0036 29<u>~ 1944</u> -10-1946 1 ☐ Yes 2 X No Specify: Specify: 3 √Widowed 4 ☐ Divorced Completed White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Foreign Service Officer US Dept. of State permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other traumatic event, the lonce. the  $5\pm$ Be 18. Mother's Name (First, Middle, Maiden Surname) Anna Dagielajski 17. Father's Name (First, Middle, Last) ပ Max Blumenfeld 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1661 Cresent Place NW Washington, DC 20009 Mark Bloomfield / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗌 Burial 2 🖾 Cremation 3 🗍 Removal from State 7/27/10 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) National Crematory 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service Licens 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Congestive Heart Failure Physician/ Medical resulting in death) Due to (or as a consequence of): MI Examiner Sequentially list conditions, if any, leading to immediate Physician/Medical Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Dav Year Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Fractured Hip 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No ၉ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 🌠 No ☐ Natural 5 Pending Trip and Fall Investigation 7-17-10 1130 2x Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
Residence 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 5215 W. Cedar Ln. Bethesda MD Hospital Medical 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 7/23/2010 D26259 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (M

Ava Kaufman MD 8218 Wisconsin Ave. Bethesda, MD 20814

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25289 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JUTY 20190 **JEANNE** Η. BELL 2<sup>5</sup>/<sub>2</sub> 7:10 Pm Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours Min. (Month, Day, Year) 37 189-32-5971 72 Pennsylvania **Director** Dec. Usual Residence of Decedent 10a. State 10b County 10c, City, Town or Location 28a-f shor 10d. Inside City Limits with the Maryland r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 🗆 Yes 2 😾 No Maryland Montgomery Germantown 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? Funeral 19915 Knollcross Drive 20876 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No Black White etc. Ś 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: White Specify: Completed 3 XWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Wilson School District Elementary/Seconday (0-12) College (1-4 or 5+) Elementary School Teacher Pennsylvania other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental h permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked c any injury or other traumatic eve anne. ဂ္ Viola Kramer Harry Frantz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19915 Knollcross Dr. Germantown, MD 20876 Deborah J. Bell (Daughter) Baltimore, Date 5, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Charles Evans Cem. 1 X Burial 2 Cremation 3X Removal from State West Reading, PA 4 Donation 5 Other (Specify) 2010 22. Name and Address of Facility 21. Signature of Funeral Service Licansee DeVol Funeral Home urtia 10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between acute Onset and Death Immediate Cause (Final Physician/ ulmonary embolism disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner P515 58 Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying attending physiclan and for use as the burial-transil Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🕱 No signed by the atte Month Dav Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 sl autopsy performed 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 🗷 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA မ this n 24 hours after death.

e Funeral Director: After th
pleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. npleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2.

To the F
complet 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

9

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LONO

Registrar's Signature

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Molecular Drive, Ste. 2 Rockville, ml 20850

29d. Date signed (Month. Day. Year)

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		For State Registrar				•	tificate of L				Reg. N	2	010	25	529
Physicia	ın/	1. Decedent's Name		e <i>, Last)</i> rd Blades I	dabas	7				2. Date of D Month July	eath 23 <sup>D</sup>	ay o	o Tab	3. Time of 6:46	f Death
Medic Examin		4a. Facility Name (if		n, give street and number			4b. City, Town, o	r Location	of Death	oury		c. County		0.40	7 141
				emorial Hos		1 1 1 1 1 1 1 1 1	Fre	ederi	.CK er 24 Hrs.	1			Frede		
Funeral Director		5. Social Security Nu <b>501–24–3</b> 3	<b>38</b> 5	6. Sex 1 <b>□X</b> M 2 □ F	Age (In yrs. I	ast birthday) Yrs.	Months Days	Hours	Min.	8. Date of B (Month, D <b>June</b>	17	1929	9. Birthp Count <b>Nort</b>	h Dako	or Foreign ota
and show 1 at	o.	Usual Residence of 10a. State	Decedent 10b. County		10c. Cit	y, Town or Lo	cation						11	0d. Inside Ci	ity Limits
Maryl 28a-f otifie	Director	Maryland		lerick	Fr	ederic									2 🗆 No
with the 23a or ist be r	eral [	10e. Street and Num		Place, E			10f. Zip Code <b>21702</b>				_	itizen of V USA	What Coun	try?	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	d by Funeral	11. Marital Status  1  Never Marri 3  Widowed	ied 2 <b>XX</b> Mar	12. Was Decede Armed Force 12 Yes Give	es? No	J.	Vas Decedent of H f Yes, specify Cuba □ Yes 2X No	lispanic O an, Mexica	an, Puerto	ecify Yes or No Rican, etc.)	)-		e - America ck, White, e		
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shoul h and h 7 is ma trauma		19a. Informant's Na					ng Address (Street					-		,	20
1 and 2 of Healt item 2 other		Rose Berd 20a. Method of Disp	osition			Place of Dispo	Baker P1 sition (Name of	:		Freder:	_		City or To		)
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permit Depart Impor any in once,		21. Signature of Fur	neral Service	Licensee	01.		Name and Addre			tauffe:					21702
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Physician/ Medical Examiner		Immediate Cause (I disease or condition resulting in death)		a. Res			Failu	ve_	-			-		Onset and [	Death
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a w :=	_	Cause (Disease or i that initiated events resulting in death) L	3	c. Due to (or	as a consequ	uence of):									
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  within 24 hours after death.  with the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 n 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?	23c. If yes, outcor 1  Live Bir 4  Pregnar 9  Unknow	th 2 🗀 Feta nt at time of o	al death 3	Ectopic pregnand Other (specify)	рy				23d. Dat	te of delive nth		Year
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ending Ph sath. vr. After thi he funeral	Certificate: 1	27. Manner of Death  1 A Natural 2 Accident	5 Pendir	28a. Date of i (Month, gation		28b. Time of injury	28c. Injury	y at		28d. Describe				-	
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the Hospii in 24 hour the Funer.	Medical	(Check 2 only one) 3	☐ Medical E	Physician: To the best Examiner: On the basis of Nurse Practioner: To	of examination	n and/or invest	igation, in my opinio	on, death o	occurred at	t the time, date	and place	e, and due	to the cau	se(s) and ma	nner stated
Mith		29b. Signature and t		Pandey.	m·D	٠.	29c. License	e number <b>6491</b> (	0		-	_	(Month, D	-	
HUNA		Pratima	Pandey	who completed cause o	of death (Item		rint) enth Stre	et,	Frede	rick,	Mar1	and	2170	1	
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DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

5:58 A

10d. Inside City Limits

1X Yes 2 □ No

9. Birthplace (State or Foreign

MARYLAND

Black, White, etc.

Month

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No

WHITE

21601

Sminites

1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> **2010 Physician** JULY 26. WILLIAM OLIN BRYAN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TALBOT 28683 HOPE CIRCLE EASTON If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 09/24/1949 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1**X** M 2□ F 60 Director 215-50-0938 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Modical Examinating must be neithed at Director MD TALBOT EASTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 28683 HOPE CIRCLE 21601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 2 should be filed within 72 hours after and Mental Hygiene. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 CONTRACTOR **EXCAVATION** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAMES MARION BRYAN PEGGY CUMMINGS ၀ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health DONNA HOPKINS BRYAN, WIFE 28683 HOPE CIRCLE, EASTON, MD Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 Department of Important: If it any injury or o once. 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State 07/30/2010 OXFORD CEMETERY OXFORD, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME,
200 SOUTH HARRISON STREET, EASTON, MD 216 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final myscardial **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a onsequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-trar Due to (or as a consequence of) P.O. Box 68760, attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) cate has been signed by the page 2 should be detached by 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed certificate 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 Mo 1 ☐ Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: A 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a Medical 29a. Certifier Le Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type\_Print)

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31. Date filed (Mont)

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State Registrar

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gistrar's Signature

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	1 - State Registrar	Certificate of Death Re	eg. No. 2010 25201
Physician/ Medical	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month ไม่ไ	3. Time of Death A
Examiner	4a. Facility Name (If not institution, give street and number)  Whiv. of Maydand Medical Ctr	4b. City, Town, or Location of Death	4c. County of Death
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Bq H1WWW   Pay) If Under 1 Year   If Under 24 Hrs.   8. Date of Birth	Baltimore  9. Birthplace (State or Foreign
Director	479-50-7531 1 □ M 2 ☑ F 67 Y	Months Days Hours Min. (Month, Day, August 11	Year) Country) , 1942 Iowa
yland f shov ed at	10a. State 10b. County 10c. City, Town of	or Location	10d. Inside City Limits
ne Maryland or 28a-f sho i notified at Director	Maryland   St. Mary's	Lexington Park	1 ☐ Yes 2 🖾 No
leath with the items 23a cer must be Funeral	21421 South Essex Drive	20653	USA
items items	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- lf Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
after or samir, or samir	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates.	1 ☐ Yes 2 🖾 No Specify:	Specify: White
5-06 hours hatur dical E	15. Decedent's Education 16a. D	Decedent's Usual Occupation Give kind of work done during most of working	16b. Kind of Business Industry
1215-003 ifthin 72 hours at lene. r than "natural" the Medical Ex	Elementary/Seconday (0-12) College (1-4 or 5+)	fe. DO NOT use retired)	Numaina Hama
d 2. led wil Hygie other ent, th	8 Cert	ified Nursing Assistant  18. Mother's Name (First, Middle, M	Nursing Home  Maiden Sumame)
/lan d be fil d be fil dental sirked arked tric ev	Lloyd Lee Briggs	Verla Mae Morga	n
Baltimore, Maryland 21215-0036 sernit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiener moortant: If item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Exam pince.  To Be Completed by		Mailing Address (Street and Number or Rural Route Number, or 21 South Essex Drive, Lexington Pa	
re, I I and 2 I Healt Item 2	20a. Method of Disposition 20b. Place of D	Disposition (Name of Date	20c. Location - City or Town, State
imo Page nent o ant: If	T Duliai Z El Oremation 5 El riginova nom state	itan Crematory August 2, 2010	Alexandria, Virginia
Baltimore, Maryland 21215-0036  permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "hatural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Mattingley-Ga P.O. Box 270,	rdiner Funeral Home, P.A. Leonardtown, MD 20650
	23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.		Interval Between
Physician/ Medical		uval Hamorrhage	Onset and Death
Examiner	resulting in death)  Due to (or as a consequence of)	O M STATE	DICAL EXAMINEN
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be executed sician and burial-transit cal Examiner	Cause (Disease or iinjury that initiated events c. Due to (or as a consequence of)		
O be ex sician burial	C <sub>d</sub>		
876 ifficate ng phy as the	IF FEMALE:		
O. Box 68760 In the death certificate E I by the attending physistached for use as the telephysistached for use as the telephysician/Medic	23b. Was decedent pregnant in the past 12 morths?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery  Month Day Year
). BC he dee y the a iched f	1   Pregnant at time of death 9   Unknown	5 🗆 Other (specify)	
E strained B	Part II. Other significant conditions contributing to death but not resulting in		acco use contribute to the cause of death?
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Division of Vital Recc To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2: Medical Certificate: To Be Comp	29a. Certifier (Check (Check only one) 3 Certifying Physician: To the best of my knowledge, de conly one) 3 Certifying Nurse Practioner: To the best of my knowled	eath occured at the time, date and place, and due to the caus nvestigation, in my opinion, death occurred at the time, date and dge, death occurred at the time, date and place, and due to the o	d place, and due to the cause(s) and manner state
To the within To the comp	29b. Signature and title of certifier	29c. License number 29	9d. Date signed (Month, Day, Year)
	In feel M	10033/	7 - 40 - 2010
to eme	30. Name and address of person who completed cause of death (Item 23a) (Ty	S Greene St. Ballimore IND :	21201
State	31. Date filed (Month, Day, Year)  32. Rigistrar's Signature	1	
Registrar	AUG 01-2010 Jenus S.	park	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Glen Burch 2010 11:55 a M August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's 22455 Bayside Road Leonardtown If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Date of Birth (Month, Day, Year) Months 1⊠M 2□F Days Hours 45 Director 214-82-6406 01/09/1965 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. snt; If item 27 Is marked other than "natural", or Items 23a or 28a-f show Jry or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 ☐ Yes 2√ No Directo Leonardtown St. Mary's Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22455 Bayside Road 20650 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert E., Burch Elizabeth J. Payne ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 and Department of Health are Important; if item 27 is any injury or other trau 38723 Robert Lacey Rd., Abell, MD 20606 Laura A. Lacey/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Charles Memorial Gr | 08/06/2010 Leonardtown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signer of uneral sensee 22. Name and Address of Facility Brinsfield Funeral Home, P Edward N. Brinsfield, Jr. M00052 22955 Hollywood Rd., Leonardtown, MD 20650 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause the children cause the complex of the comple Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** O.V /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the carrier Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physician for use as the hurial Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No Division or Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn certificate 2 No 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 27. Manner of Death Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28h Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Yes 2 No ours after death.

neral Director: #
filled in by the fi 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral
completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

State Registrar

Jennif# Schmidt, D.O. 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and addres

40900 Merchants Ln., Leonardtown, MD 20650

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** ONEITA FORNEA BURDETTE 7/24/2010 6:55 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7 MANITO DRIVE DORCHESTER CAMBRIDGE If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2**X** F Director 434-24-5511 88 03/14/1922 LOUISIANA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is Medical Evantice input to a reaffie 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Directo MARYLAND DORCHESTER CAMBRIDGE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 MANITO DRIVE 21613 **USA** Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes. Give Specify δ Widowed 4 ☐ Divorced Year or Dates: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **HOMEMAKER OWN HOME** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **IDDO BALL FORNEA BEULAH FARRELL** ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEBORAH BURDETTE IHRMAN / DAUGHTER 13 HATSAWAP RD., CAMBRIDGE, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MID SHORE CREMATION CENTER 07/26/2010 CAMBRIDGE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MID SHORE CREMATION CENTER 2272 HUDSON RD., CAMBRIDGE, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) ETTICN /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) The law requires that the death certificate be executed Exami and burial-trai Due to (or as a consequence of) attending physician for use as the buria Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No the detached 9 Unknown tor: After this certificate has been signed the funeral director, page 2 should be dei 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 2 🗆 No 1 □ Yes 2 1 At 1 ☐ Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🖳 KO Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Date of Injury (Month, Day, Year) 27. Mann f Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Unatural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deat To the Funeral Director: Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 29a. Certifier i 🖰 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 105 RKENDON PAL 31. Date filed (Month, Day, Year) Registrar's Signature State

Registrar DHMH 17 Rev 1/2001 JUL 2 9 **2**01

Baltimore, Maryland 21215-0036  $^{\prime\prime}$ 

Division of Vital Records, P.O. Box 68760.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 25295 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7/21/2010 THADDEUS MARTIN BORZ, SR. 9:05P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CHESAPEAKE WOODS CENTER CAMBRIDGE **DORCHESTER** 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🛛 M 2 🗆 F Months Days Hours Min NEW JERSEY 874/1935 Director 148-28-5325 74 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Tes 2 No MARYLAND DORCHESTER **CAMBRIDGE** 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 5841 HUDSON WHARF RD 21613 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. \$ 1 Never Married 2 Married If Yes, Give 1 ☐ Yes 2X No Specify: Specify. 3 Divorced Completed WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **BANKER FINANCIAL** 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) THADDEUS A. BORZ HELEN MARY SKORUPSKI. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5841 HUDSON WHARF RD., CAMBRIDGE, MD 21613 PATRICIA A. BORZ / WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 7/23/2010 CAMBRIDGE, MD 4 ☐ Donation 5 ☐ Other (Specify) MID SHORE CREMATION CENTER 21. Signature of Funeral Se 22. Name and Address of Facility CURRAN-BROMWELL FUNERAL HOME, P.A., 308 HIGH ST., CAMBRIDGE, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line MUMSTIS Immediate Cause (Final Onset and Death

Physician Medical Examiner

"natural", or items 23a or 28a-f show

burial-tran anding physician a use as the burialpage 2 s completed filled in by the funeral director,

the Hospital or Attending Physician; The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

	disease of condition	a. // 0[ ]	113			Collect
	resulting in death)	Due to (or as a consequence of):				
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury	b. Due to (or as a consequence of):				
-	that initiated events resulting in death) Last	C. Due to (or as a consequence of):  d.				
ysician/Medical	IF FEMALE; 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown		Ectopic pregnancy Other (specify)		23d. Date of de Month	blivery Day Year
ompleted by PI	Part II. Other significant conditions of the Color VAS CV	ontributing to death but not resulting in the call of Accident	A COAL COOK	1 □ Yes	2 × 3 □ F	or the cause of death?  Probably 4 Unknown
dwoo	Deplession	DIAMETER	1-1/(E-X)/A)	24a. Was an autopsy perform 1 \(\sum \text{Yes}\) 2	prior to death?	utopsy findings available completion of cause of ss 2 \square No
9	25. Was case referred to medical		26. Place of Death (Ch	eck only one)		
0	examiner? 1  Yes 2  No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	t 3 DOA Other: 4 Wursing	Home 5 Residen	ce 6 Other (Spec	cify)
ertificate:	27. Manner of De h  1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not b		28c. Injury at work?  M 1 Yes 2 No	28d. Describe how	injury occurred	
٥	4 Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Stre City or Town,	et and Number or Ru State)	iral Route Number,
Medical	(Check 2 L Medical Exami	sician: To the best of my knowledge, death iner: On the basis of examination and/or invesse Practioner: To the best of my knowledge,	igation, in my opinion, death occurre	d at the time, date and	place, and due to the	cause(s) and manner stated
	29b. Signature and title of certifier		29c. License number	290	d./Date signed (Mont	h, Day, Year)

State

Registrar

31. Date filed

ess of person who completed cause of death (Item 23a) (Type, Bright)

2. Registrar's Signature

LOSAM-RRP.O

JUL 29 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [ ] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 1405 M TOWELL BASSETT -ALICE 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** POINT KENT HESTERTOWN Year If Under 24 Hrs. 8. Date of Birth Days Hours Min. (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Year) Months Days 1 □ M 2 😿 F 9 Country)
5 PAIN 217 02 1964 Director 1918 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exercites it into the Legisla of 2006s. 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 XYes 2 No KENT Funeral Director MO HESTERTOWN 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number HERON POINT 21620 203 KRITAIN 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 | Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ WHITE 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMENAKER 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LDWARD 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Hoiry PATRICIA HARBOR 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State SANDI BUTTIM RD 8/7/2010 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
MARVIN U. WILLIAMS TE FUNELAL DIRECTOR 21/20 MO 21. Signature of Funeral Service Licensee 205 CREEN HERON UM 120 5,0886 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory ar shoot, or heart failure. List only one cause on eady line. Immediate Cause (Final 17 CART BILMS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner seque trally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent premant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) P.O. I 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has t rector, page 2 s autopsv performed 1 □Yes 2 🖬 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 27. Manner of Death 1 ☐ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 ☐ Yes 2 🗆 No within 24 hours after death

To the Funeral Director; A 2 Accident Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of ce

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Ma	ai yiariu	•	tificate of E		іментаі пу	Reg. No	010	25297
	Physicia	n/	1. Decedent's Name (First, Middle, Last						2. Date of De Month Ju	ath 1y Day	A Xear A	3. Time of Death
	Medic	al	Angela Ruth Barila  4a. Facility Name (if not institution, give s									8:20 pM
	Examin	er	Chester River Hosp				4b. City, Town, or Chestert		.n	Ke Ke	ounty of Death	
	Funeral		5. Social Security Number 6. Se:	7. Age	(In yrs. last	t birthday)	If Under 1 Year	If Under 24 Hrs		th	9. Birth	place (State or Foreign
	Director		033-52-919/	] M 2 🗓 F	51	Yrs.	Months Days	Hours Min	(Month, De 10/15)	1958	Cour	MA MA
	how at	r	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Loc	ation	<del></del>	<del> </del>			10d. Inside City Limits
	arylar ta-fsl	Director	MD Queen Ann			estert						1 ☐ Yes 2 🖾 No
	or 28 e not		10e. Street and Number	16 5	Offe	STELL	10f. Zip Code			10g. Citize	en of What Cou	ntry?
	s 23a	Funeral	358 High Point La	ine			21620			Ţ	JSA	
	death item		11. Marital Status	12. Was Decedent E Armed Forces?		13. W	/as Decedent of Hi Yes, specify Cuba	spanic Origin? (S n, Mexican, Puer	pecify Yes or No- to Rican, etc.)	14	I. Race - Americ Black, White,	
36	after al", or Exami	d by	1 Never Married 2X Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🔀 If Yes, Give Year or Dates,	No	1	☐ Yes 2X No	Specify:		Sp	pecify: Whit	
Maryland 21215-0036	hours natura lical E	Completed	15. Decedent's Ed	ucation	- 1	16a. Deced	ent's Usual Occupa	ation			d of Business In	
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ano	ntal F red of	To B	17. Father's Name (First, Middle, Last)  Peter Sheaffer						me <i>(First, Middle,</i> .ev E11i		rname)	
<u></u>	nd Me		19a. Informant's Name/Relationship (Type	oe, Print)		19b. Mailin	g Address (Street a				own, State, Zip (	Code)
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o G	of He		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐		20b. Pla	ce of Dispos	sition (Name of natory or other plac	e)	Date	20c. Loca	ation - City or To	own, State
Ĕ	Page tment tant: jury o		4 Donation 5 Dother (Specify	1	1	sapeak	e Cremat	ion 8/2	/2010	Steve	ensville	e, MD
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	6 95	21. Signatur of uneral Service Licens	112			Name and Addres					Newnam
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on	ications that caused	the death.						21020	Approximate
	hysician/		Immediate Cause (Final			laston	no hou	1tifor	***		- 1	Odset and Death
	Medical	î	disease or condition resulting in death)	Due to (or as a			THE THIN	(1)13	1110			2 mo-
	Examiner	<u>*</u>	Sequentially list conditions,	0. —								
	ed sit	Examiner	if any, leading to immediate cause. Enter Orderbyrg Cause (Disease or iinjury	Due to (or as a	consequer	nce of):						
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09/89	tificat ng ph		IF FEMALE:									
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ň	ne deg y the g	Physician/N	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	- unite of dea	atii 5 🗆	Other (specify)					
5	that the ned by a deta	by PI	Part II. Other significant conditions co			_	nderlying cause giv	en in Part I.	23e. Did t	obacco use	contribute to t	he cause of death?
ds,	quires en sig ould b	led l	Hyportension,	Thrombo	ntop	ens			1 🗆	Yes 2	No 3□ Pro	bably 4 🗌 Unknown
Division of Vital Records,	aw rei ias be	Completed							24a. Was auto	psy	prior to co	psy findings available impletion of cause of
Y Y	: The I	Con							perfo	ormed?	death? 1 ☐ Yes	2 100
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<u> </u>	y Physer this eral di	e: To	27. Manner of Death	28a. Date of injur	y 2	R/Outpatien 8b. Time of	t 3 □ DOA 28c. Injury	4 □ Nursing	Home 5 Resi 28d. Describe			)
000	anding tath. rr: Afte	ficat	1 Natural 5 Pending 2 Accident Investigation	(Month, Day	; Year)	injury	M 1 □	? Yes 2 🗌 No				
N S	or Atter frer de irecto n by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc		e, farm, stre	et, factory, office		28f. Location ( City or Tox		Number or Rura	l Route Number,
5	pital o	D 0.0	29a, Certifier 1 Certifying Physi	eign. To the best of	my lenousloa	dan dooth o	noured at the time	data and place	and due to the or	was(a) and	mannar as state	(I)
	To the Hospital or Attending Physician. The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical		er: On the basis of ex	kamination a	and/or investi	igation, in my opinic	n, death occurred	at the time, date	and place, a	nd due to the ca	use(s) and manner stated.
	To the withing the complex com	~	29b. Signature and title of certifier				29c. License	number			signed (Month,	
	15		1		ND		Da	05173	>5	8	2/10	
	ms		30. Name and address of person who co				*					
	Stat	e	Frederick Dell 31. Date filed (Month, Daug 03	2. Registra	r's Signatur	re 2	Church	Hill	t. Che	stert	D17014	1021620
	Registra	ır	AUG V 3	ZUIU La	ance a	13.	A CONTRACT					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ July 23, 11 AM Tsui-Lan Chang Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 12916 Larkin Place Rockville Montgomery Social Security Number If Under 1 Year Funeral 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 1 ☐ M 2 🛣 Days Hours 12/23/X935 China **Director** 216-90-9727 74 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I firem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. the Madical Exercises. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ▼ Yes 2 No MD Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12916 Larkin Place 20853 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Yes Yes Yes, Give Baltimore, Maryland 21215-0036 Asian ☐ Yes 2 X No Specify: Specify: 3 XWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Restaurant Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15529 Grinnell Terrace Derwood, MD 20855 Lydia Chang - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 **X** Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park 7/28/2010 Rockville, MD 21. Signature of Funeral Service Licensee Bansky Goldwerg Memorial Chapels Inc O Rockville Pike Rockville MD 20852 MChelenny MO1597 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the moshock, or heart failure. List only one cause on each line. Approximate Interval Between On Chand Death Immediate Cause (Final Physician/ disease or condition resulting in death) mouth Medical Due to (or as a consequence of) Examiner constraint flat execution as Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Other (specify) Month Day Year signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has bage 2 s autopsy performe certificate 1 Yes 2 No Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 

Residence 6 ☐ Other (Specify) : After this e funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5  $\square$  Pending thin 24 hours after death.

the Funeral Director: Aformpleted filled in by the fu 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) tle of certifier 29b. Signature and no completed cause of death (Item 28a)

State

Registrar

31. Date

9

2. Registrar's Signature

		ļ	1 - For State Registrer	ate of Maryland		artment of tificate of		d Mental H	ygiene		25299
			Decedent's Name (First, Middle, Last)					2. Date of I	Death		3. Time of Death
195	Physici /Medic		Blanco	r E. Carde	nas			Jul.	y 24,		12:30pm
	Examin		4a. Facility Name (If not institution, give stree	•			or Location of De		4c.	County of Dear	
			Apex Nursing Hor	ne. 7. Age (In yrs. Ia:	at high-doul	Sil.	ver Spr		Dieth		tgomery
H	Funeral Director		578-60-4153		Yrs.	Months Days		lin. (Month, 10/09	Day, Year)	Co	thplace (State or Foreign puntry) .atemala
	D		Usual Residence of Decedent					110/07	/ 1 / 1 0		
	anylan ahow	_	10a. State 10b. County		Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 🛛 No
	28a-f	ecto	Maryland Montgome  10e. Street and Number	ry		T	Cockvill	e	10m Cit	izen of What Co	
	with t	直	13717 Woodlark D	rivo		10f. Zip Code	20853		Tog. Cit		.S.A.
	ms 23	Funeral Director	11. Marital Status 12. V	Vas Decedent Ever in U.S.	. 13. y	Vas Decedent of		(Specify Yes or Jerto Rican, etc.)	No-	14. Race - Ame	erican Indian,
و	or Ita	Fur	1 Never Married 2 Married 1	\rmed Forces? □Yes 2∏No !Yes, Give	1	t Yes, specify Cul 1.22 Yes 2				Black, Whit	
က္က ဂ	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f ahow ha Modical Examilian in and ke modifical at	d by	3 X Widowed 4 Divorced	ear or Dates:				iatemalai			White
<u>5</u>	n 72 h	Completed	15. Decedent's Educatio (Specify only highest grade con		16a. Deced (Give	tent's Usual Occu kind of work done DO NOT use retin	upation e during most of t ed)	working	16b. K	ind of Business	/Industry
212	iene.	omp	Elementary/Secondary (0-12)	College (1-4or 5+)			Maker			Res	taurant
פ	e filed al Hygid othar vant, il	Be C	17. Father's Name (First, Middle, Last)				18. Mother's I	Name (First, Midd	ile, Maiden	Sumame)	
Maryland 21215-0036	should be ind Mental in marked c	ToE	Hermogene	s Gonzalez				Pili	ar Du	arte	
Jar	2 sho		19a. Informant's Name/Relationship (Type, F			-		Rural Route Nur	-		
	1 and Health am 27 thar t		Beverly Cumes - Gray 20a. Method of Disposition					y, Spring	-	a, VVIG. ocation - City or	inia 22152 Town State
timore,	Pages nent of I ant: If its arry or o		1 X Burial 2 ☐ Cremation 3 ☐ Remo	variioni State		sition (Name of natory or other pl	1				
≣,	Pfermit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or Items 23a or 28a-f ahow any injury or othar traumatic evant, it is Modical Examiliar injurities and once.		<ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. Signature of Funeral Service Licensee</li></ul>	1 17							Maryland l Home, Inc.
			Annellaneh	arher							ng, MD 20904
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one car	ns that caused the death.						•	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Nodula Due to (or as a conseque	r Ly	imphon	na				Unknow
	/Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):						
		-	Sequentially list conditions, b	Due to (or as a conseque	ence ou.						
	uted d ansit	Examiner	Sequential y list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.								
o o	exec an an rial-tra		resulting in death) Last	Due to (or as a conseque	ence of):						
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٠ ×	death certifica attending ph for use as th	/Med	IF FEMALE:	Luca autoema of access							
Box	that the death cer ed by the attendir detached for use	sian,	in the past 12 months?	f yes, outcome of pregnand □Live birth 2□Fetal d □Pregnant at time of dea	death 3	Ectopic pregnan Other (specify)	су			23d. Date of de Month	Day Year
Р. О.	the d	nysi		Unknown		2 - 11 - 11 - 12 - 13 - 13 - 13 - 13 - 1					
ω̂.	res that igned b	by P	Part II. Other significent conditions contribu	iting to death but not result	ting in the u	nderlying cause g	iven in Part I.	23e. Di	d tobacco i	use contribute to	o the cause of death?
ğ	w require been sig should b		almentia					1{	∏Yes 2	□No 3□P	robably 4 Unknown
Vital Records,	has be	Completed	Anemia						itopsy	prior to	utopsy findings available completion of cause of
T T	: The cate h	Con	Hypertensi	on				pe 1 ☐ Yes	rformed? s 2 No	death? 1 ☐ Yes	3 2□ No
<u> </u>	ilcian: Th certificate rector, pag	Be	25. Was case referre to medical examiner?	tal: 1 ☐ Inpatient 2 ☐ E		_ 0		Death (Check on			
ō	Attending Physician: r death. sctor: After this certifics by the funeral director, p	5		Ba. Date of Injury 2	PVOutpatien 28b. Time of			g Home 5 Re			ocify)
o	nding ith. :: Afte e fune	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		onk? ⊒Yes 2.∐No				
Division of	or Attending after death. Diractor: After in by the funer	Certification;	a Could not be	Be. Place of Injury - At hom building, etc. (Specify)	ne, farm, str	eet, factory, office	•		n (Street ar Town, State		ural Route Number,
5	ospital or A hours after unaral Dira ly filled in b										
	Hospital 24 hours a Funaral tely filled	edical	(Check only 2 Medical Examiner:	n: To the best of my know On the basis of examination							
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funaral Diractor: After this certificate he completely filled in by the funeral director, page	Med	29b. Signature and title of certifier	and manner stated.		29c. Licer	nse number			te signed (Mon	
	- 3 - 5		· Chowdy			0	43121			7/26/1	
	•			eted cause of death (Item 2	23а) (Туре,	-	,		1	, ,	
			NURUL CHOWDHU	ated cause of death (Item 2 2 y , MD ; 15 2 32. Registrar's Signatur	16 DI.	NO DRIV	ie, bur	RTONSY	126	MD	20866
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	Some A	20					
	Registr	ar	JUL 29 2010 A	severa p.	d	10-4					

			For State Registrar	State of Ma	arylan		artment of F tificate of D			1ental Hy	gien Reg. N	7	) ;	25300
	Physicia	ın/	Decedent's Name (First, Middle, I	_ast)						2. Date of De	eath	ay Year		3. Time of Death
	Medic Examin	cal	JESSIE  4a. Facility Name (if not institution, g	ive street and number)	CO	OK	4b. City, Town, or	Location	of Death	JULY	27	7 2010 c. County of De		1:30 P M
	Examin	ler	LARKIN CHASE		ME		BOWIE	Location	Orbeatti			PRINCE (		RGE'S
	Funeral Director		5. Social Security Number 6 579-01-3509	. Sex 7. Age	(In yrs. la	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Unde Hours	er 24 Hrs. Min.	8. Date of Bir (Month, Da OCT • 1	av. Year)	0	ountry)	e (State or Foreign
	nd how at	'n	Usual Residence of Decedent 10a. State 10b. County		10c, City	y, Town or Loc	cation						_	Inside City Limits
	Maryla 28a-f s otified	Director	MD PRINCE	GEORGE'S	CAI	PITOL 1	HEIGHTS							1 🅅 Yes 2 □ No
	th the l	al Di	10e. Street and Number				10f. Zip Code				10g. C	itizen of What C	Country	?
	ems 2	Funeral	6302 CARRINGTON  11. Marital Status	12. Was Decedent E	ver in U.S		2074 Vas Decedent of Hi	spanic C	rigin? (Spe	cify Yes or No-	US -	14. Race - Am	nerican	Indian.
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ğ	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1  Yes 2  II If Yes, Give Year or Dates.	No	11	Yes, specify Cubar	n, Mexic	an, Puerto I	Rićan, etc.)		Black, Wh Specify:	ite, etc.	
15-0	72 hour	Completed	15. Decedent's (Specify only highest			(Give F	lent's Usual Occupa	ation Juring mo	st of worki	ng	16b.	Kind of Busines	s Indus	try
21215-0036	within jiene.	Con	Elementary/Seconday (0-12) u/k	College (1-4 or 5-	+)	PRES	O NOT use retired) SSER					PRTVATE	₹.	
pue	e filed vatal Hyg ed othe event,	To Be	17. Father's Name (First, Middle, Las	t)						(First, Middle				
aryle	ould b nd Mer mark		GOLDEN FOSTER  19a. Informant's Name/Relationship	(Type, Print)		19b Mailin	g Address (Street a			MCELWE		or Town, State, 2	Zin Cod	'el
Ž,	nd 2 sh ealth a m 27 is ner trau		THOMAS T. CHEEK	I/NEPHEW			TYROL DR							
Baltimore, Maryland	Page 1 ar nent of H int: If ite		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3  4 ☐ Donation—5 ☐ Other (Spe		C	emetery, crem	sition (Name of natory or other place CEMETERY		8/5/2	0ate		ocation - City o		
Balti	permit. I Departm Importa any inju	(	21. Siseature of Fundial Service Lic			22	Name and Addres	s of Faci	lity J.	B. JE	NKIN	IS FUNER	RAL	
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	hysician, Medical	0.0	Immediate Cause (Final disease or condition resulting in death)	aCOMP			FROM FOOT	GA	IGRENI	Ξ				nset and Death
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	ertificat ding ph se as th	/Mec	IF FEMALE:	23c. If yes, outcome of	of pregnar	ncv					I		_	
Division of Vital Records, P.O. Box 68	The law requires that the death certific ate has been signed by the attending I page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒No 9 ☐ Unknown	1  Live Birth 2 4  Pregnant at 9  Unknown	? 🗌 Feta	Ideath 3	Ectopic pregnance Other (specify)	у			ĺ	23d. Date of d Month	lelivery Da	y Year
P.0	s that th gned by oe detac	by	Part II. Other significant conditions	contributing to death bu	it not resi	ulting in the u	nderlying cause give	en in Par	t 1.			use contribute		
ords	require been si should	eted								1 □ 24a, Was				ly 4 Unknown findings available
Reco	The law ate has page 2	Completed								auto perfe		prior to death?	compl	etion of cause of
Ita	sician; certific irector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:		<b>50</b> /0 / 11	_ Othe	r·	ath (Check					
<u>o</u>	To the Hospital or Attending Physiciam: within 24 hours after death.  To the Funeral Director After this certific completed filled in by the funeral director,	ate: To	27. Manner of Death 1   Natural 5 □ Pending	28a. Date of injury (Month, Day,	/ T	ER/Outpatien 28b. Time of injury	28c. Injury works	at	2	me 5 ∟ Resi 28d. Describe l		6 ☐ Other (Spe ry occurred	ecify)	
ISION	Attendi sr death ector: A by the fi	Certificate:	2 Accident Investigat 3 Suicide 6 Could no 4 Homicide determine	t be 28e. Place of Injur				Yes 2				nd Number or R	ural Ro	ute Number,
2	oital or urs afte ral Dir			building, etc.						City or Tov				
	he Hosp in 24 ho he Fune pleted f	Medica	(Check 2 Medical Exa	hysician: To the best of n miner: On the basis of ex prse Practioner: To the b	amination	and/or investi	gation, in my opinio	n, death	occurred at	the time, date a	and plac	e, and due to the	e cause(	
	Vith to to to to to to to to to to to to to		29b. Signature and title of certifier	1/10/			29c. License					ate signed (Mon		
	2		30. Name and address of person wh	o completed cause of de	ath (Item	23a) (Type, Pi		3351			J	ULY 28,	20	10
	EL		OKWARA IKECHIE	M.D. 12200	ANN	APOLIS	,	316	GLENI	DALE,	MAR?	YLAND :	2076	59
	Stat Registra		31. Date filed (Month, Day, Year)	32 Registrar	's Signati	bar	Kel							

oger Clifford C	JOI S	ey State 1- For State Registrar	te of Maryland /	•	rtificate of D		u Mentai	, ,	eg. No. 2010	25301
Physici Medical Exam		Decedent's Name (First, Middle,t     ROGER	Last) CLIFFOI	RD	CORSE	Y		2. Date of Dea Month July 31, 2	Day Year	3. Time of Death 0106 hrs
W.		4a. Facility Name (if not institution, 2021 Brooks Drive, #10	-	•		City, Town, or orestville	Location of De	ath	4c. County of Dear Prince Georg	
Funeral Director				e (In yrs. I:		Months Day		Hrs. 8. Date of Bir	th(MM/DD/YYYY) 9. Bi 21 1927 Fore	irthplace (State or ign VIRGINIA ountry)
any		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Location					10d, Inside City Limits
* .	ō		GEORGE'S		FORESTVI					1 X Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number	VE # 107		11	0f. Zip Code 2074	7	1	Og. Citizen of What Cou USA	intry?
h with tl ems 23a t be noti	Funeral	2120 BROOKS DRI  11. Marital Status  1 X Never Married 2 Marr	12. Was Decedent I		I If Vac	ecedent of His		Specify Yes or No		rican Indian, Black,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygerne. Important: If tienen 77 is marked ofter than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once			1 X Yes 2 Ced If Yes, Give Year	∏ <sub>N</sub> AI	RMY	s 2 X No		,	Specify: BLA	CK
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nore, MD 21215-0036 ages I and 2 should be filed within 72 nt of Health and Mantal Hygene. It. If tien 27 is marked other than other traumatic event, the Medical other traumatic event, the Medical.	Be Co	17. Father's Name (First, Middle, La ROGER EDWARD			_		18.Mother's Na MARY	me (First, Middle, I	· · · · · ·	
212 should be nd Ment is mark	P P	19a. Informant's Name/Relationship	(Type, Print)				et and Number of	or Rural Route Nur	nber, City or Town, Stat	
e, M( l and 2 s Health a item 27		FLOYD ALFRED CO		20b. F	Place of Disposition	n (Name of ce		Date DU	WIE, MARYLA 20c. Location - City o	
imor Pages ment of lant: If or other		1 Burial 2 X Cremation 4 Donation 5 Other Spec	city:	4	VERDALE C	CREMATO		4/2010	RIVERDALE,	,MARYLAND
Balti permit. Departi Import		21. Signature of Funeral Service Lie	Sensee			e and Address		J.B. JEN D LANDOV	KINS FUNERA ER, MARYLAN	AL HOME ND 20785
Physician		23a. Part I. Enter the disease, or confailure. List only one cause or	each line. Ather	cosc1	Do not enter the n	node of dvina	such as cardia	or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and
Examiner	12	Immediate Cause (Final disease or condition resulting in death)	a. By Hy  Due to (or as a conse	pert	hermia					Death
	ا ا	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	quence of	f):					+
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cecuted n and rtransit			d. AMENDED 23a	. 27	28a_f_pa	r mo o	007 Q_1	0_10 vt		-
60, ate be exe ohysician te burial -	Medical	■ UNPENDED  IF FEMALE:	23c. If yes, outcom			т ше в	907 9-1·	0-10 VC	23d. Date of deliver	у
Box 68760, death certificate be he attending physic of for use as the bur dor use as the bur	hysician/A	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at t		2 Fetal o	death 3 (Specify)	Ectopic preg	nancy	Month	Day Year
he he	Physi	1 Yes 2 No 9 Unkno	9 UTKHOWN	but not ro			nivon in Part I	23e Did to	obacco use contribute to	the cause of death?
P.O.	δ	Part II. Other significant condition	is contributing to death	baction	ssulang in the unde	errying cause (	given in Fait i.	111	s 2 ✓ No 3 Pro	
of Vital Records, g Physician: The law requir The this certificate has been si neral director, page 2 should t	Completed							24a. Was autop	sy prior to	utopsy findings available completion of cause of
Rec r: The la ifficate h		25. Was case referred to medical				26 Place	e of Death (Chec	1 🗸 Yes	med? death? 2 No 1 ✓ Y	es 2 No
Vital hysician this cert	o Be	examiner?  1 ✓ Yes 2 No	Hospital: 1 Inpatier	nt 2	ER/Outpatient 3		Othor	sing Home 5	Residence 6 🗸 Othe	
on of nding Pl th. :: After te funera	ion: T	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injur (Month, Day,Ye	ar)	28b. Time of Injur		ry at Work? Yes 2 χ No			ubject found
Division spital or Attendi spital or Attendi hours after death. Ineral Director: A filled in by the fi	ertification:	2 Accident Investig 3 Suicide 6 Could n	gation 10 7-31-		fd 1:00a ome, farm, street, fa	ш			n environme  Street and Number or Ri  tate) 2021 Rrc	ural Route Number, City
spi nou fill	ပ	4 Homicide determi	ned (Specify) sician: To the best of my	hous		at the time da	ate and place, a	Forest	ville, Md.	
To the Howithin 24 Post to the Full Completely	Medical	one) 2 Medical Examin	ner: On the basis of exam and manner stated.	nination a	nd/or investigation,	in my opinion	, death occurred	d at the time, date	and place, and due to the	ne cause(s)
	Σ	29b. Signature and title of certifier	. 116 11			29c. Licens			29d. Date signed (Mo July 31, 2010	nth, Day, Year)
>		30. Name and address of person wh								
	fate	Margarita Korell MD.  31. Date filed (Month, Day, Year)	Assistant Medical E			Street, B	altimore, MI	21201		
Regis		AUG 0 6 2010	32. Registrar	9. 4	racks					

DHMH 17 Rev 1/2001 OCME 2006

10-0	5584	
Lois	Marie	Coves

s Marie Coves		1- For State	ate of Maryl		artment of ertificate of			Menta	al Hy		eg. No.	2010	25302
Physicia edical Examir	ın/	1. Decedent's Name (First, Middl								. Date of Dea Month	th Day	Year	3. Time of Death 0615 hrs
cuicai Examiii	IGI	LOIS MARIE CO  4a. Facility Name (if not institutio		umber)	[4	4b. City, To	wn, or Lo	ocation of		July 26, 2		County of Dea	
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any		10a. State 10b. County		10c. City	, Town or Locati	on							10d. Inside City Limits
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or 28a	Director	10e. Street and Number	DTHE			10f. Zip C						en of What Co	
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5-0036 led within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once	Funeral		arried Armed F	2 <b>X</b> No	lf Y	es, specify	_		Puerto R	ican, etc.)		White, etc.	
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9036 within 77 iene. er than	팂	12	1			WAI	TRES					FOOD	
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MD 12 sh th an 127 i		MARGARET LANGEL  20a. Method of Disposition	LO	Tank									21012
Baltimore, permit. Pages I and Department of Heal Important: If iten injury or other tra		1 Burial 2 Cremation	3 Removal f	rom State	Place of Disposi crematory or oth	er place)				T <sub>0</sub> 3,		•	or Town, State
Itim it. Pag utment ortant:		4 Donation 5 Other Sp 21. Signature of Funeral Service		GAR	DEN OF 1	MEMOR ame and A			20	10	TAM	PA, FL	ORIDA
Balt permit Depart Impor injury		Thomas K.	Helsen	heir	FEL	LOWS.	HEL	FENBI	EIN STGA	& NEWN TE ROA	AM C D, AN	REMATI NAPOLI	ON & FUNERAL S,MARYLAND 2
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Box te death the atte	Physic	1 Yes 2 No 9 Unk	nown 9 Unkn		⊃ Oth	ier (Specifi	" <u> </u>						
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e law r e has b ge 2 sh	Completed						_			autop	med?	death?	
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of Vital Records, ng Physician: The law requir After this certificate has been s nneral director, page 2 should b	B o	examiner? 1  Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatient	3 DO	Α J <sup>Ot</sup>	her 4 🔲 N	Nursing I	lome 5	Residenc	e 6 🗸 Oth	er: Scene
n of ding Ph	ü	27. Manner of Death  1 Natural 5 Pend	28a. Date	of Injury Day,Year)	28b. Time of In FOUND:			at Work? s 2. ✔ No	le,	3d. Describe h u <b>bject fell</b>	ow injury	occurred	
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0 - 3 -	cal C	1	nysician: To the bes										
To th withi To th	Medica	2 Medical Exam 29b. Signature and title of certifier	and manner s		ma/or investigati		icense n		ii eu al li	e line, date a			onth, Day, Year)
SAS	-	Que I	0]				D.C.M.					6, 2010	,
JIV	}	30. Name and address of person	who completed caus	se of death (Item	23a)								
			istant Medical I		111 Penn St			, MD 21	1201				
Sta Registr	_	31. Date filed (Month, Day, Year)	28 2010 32. Re	edistrar's Signatu	Jre 8. 400	enter							

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 | 0 25303 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month <sup>Day</sup> 2010 Physician/ 21 8:00 P M Conover July Joyce Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Centreville Queen Anne's Hospice of Queen Anne's 9. Birthplace (State or Foreign Country) New Jersey If Under 1 Year If Under 24 Hrs. 5 Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗶 F Months Days Hours (Month, Day, Year) 136-32-8164 68 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 🗌 Yes 2 📮 No Maryland | Queen Anne's Barclay 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21607 1507 Merrick Corner Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married ş Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Education Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I Important; If item 27 is marked c any injury or other traumatic eve Louis Hickson Jeanette Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1515 Merrick Corner Road Barclay, Maryland 21607 Joyce Kline / daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/28/2010 Sudlersville, MD Sudlersville Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home 130 Speer Rd. Chestertown, MD 21620 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
ONTUS Immediate Cause (Final Metastatic Neuro Endocrine Tumor Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes No Month Dav Year Pregnant at time of death signed by the at d be detached for 1 Yes 24 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ DMTZ/DOZI Hx Basa ( Coll Canov 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certificate: To Be Other: 4 🗆 Nursing Home 5 🗀 Residence 6 💆 Other (Specify) Hospice 1 Yes 2 🕅 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No iniury 1 Natural 5 Pending

To the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 nin 24 hours after death.

the Funeral Director; After this certificate has been singleted filled in by the funeral director, page 2 should within 24 hours a

To the Funeral C

completed filled i

3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check з 🗍 only one) 29d. Date signed (Month, Day, Year, 29c. License number D0050996

State Registrar

S

Accident

Mi 31. Date filed (Month, Day, Year)

or person who completed cause of death (Item 23a) (Type, Print)

Investigation

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2010 Physician/ Month Francis Roger Dean <u>11:</u>30 p.₩ August Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital Leonardtown St. Mary's 5. Social Security Number if Under 1 Year If Under 24 Hrs Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F 08/10/1924 Mary Land Director 219-12-4083 85 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits 28a-f 1 X Yes 2 No Maryland St. Mary's Leonardtown 5 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 22680 Cedar Lane Court, Apt. 1203 20650 United States items death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 A Yes 2 If Yes, Give Black, White, etc. 0 1 Never Married 2 Married þ 2 No Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Home Builder Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Roger H. Dean Gladys Dixon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau William R. Dean/Son 43935 Sandy Bottom Road, Hollywood, MD20636 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Aloysius Cemetery 08/05/2010 Leonardtown, MD Signature Mineral Service Edward N. Brinsfield, 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Jr. M00052 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition COPD Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events CHF Examine Due to (or as a consequence of): sician and burial-trans Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box ned by the atten Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be Records, Type 2 Diabetes 1 ☐ Yes 2 ☐ No 3 🖾 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypertension page 2 s has autopsy perform certificate Acid Reflux Disease Yes 2 X No 1 ☐ Yes 2 ☐ No Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Tyes 2 XNo 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 X Natural (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No s after death. I Director: Af d in by the fu ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated To the Hosp within 24 ho To the Fune completed fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 08

Registrar
DHMH 17 Rev 7/2009

State

'ORMe

(Syan)

25500 Point Lookout Road, Leonardtown, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Registrar's Signature

Mehrdad Akhlaghi,

AUG U 4 2010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JULY **EDWARDS** BESSIE 2010 11:50 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death SOUTHERN MARYLAND HOSPITAL PRINCE GEORGE'S CLINTON Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours Min 1  $\square$  M 2 Months NORTH CAROLINA Yrs Director 243-52-2109 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director ems 23a or 28a-f sl r must be notified a 1 Yes 2 No MD PRINCE GEORGE'S UPPER MARLBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17126 FAIRWAY VIEW LANE 20772 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Force Black, White, etc. ō þ 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: BLACK Specify: "natural" Completed 3 Widowed 4 Divorced Year or Dates Page 1 and 2 should be filed within 72 hour ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natu ury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 3 YRS NURSING ASSISTANT GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ JOHN ANDERSON HELEN MCCLEANON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LEE EDWARDS/HUSBAND 17126 FAIRWAY VIEW LANE UPPER MARLBORO, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or MD VETERANS CEMETERY ! 8/2/2010 CHELTENHAM, MARYLAND 4 Donation 5 Other (Specify) J. B.JENKINS FUNERAL HOME Signature of Funeral Service Licensee 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ 1 SSIW disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending hours and the attending physician and hed for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 X Pregnant at time of death 1 Yes 2 9 Unknown cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🗓 No Yes 2 No To the Funeral Director: After this certific completed filled in by the funeral director, å 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 | No 잍 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🗲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 7126 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2010 25306

For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 25, 2010 MILDRED LOUISE EURY 8:50 АМ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Glade Valley Nursing & Rehab. Ctr. Walkersville 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 6 Sex **Funeral** June 26, 1926 Days Hours 1 □ M 2 🖵 F Maryland Director 220-16-3006 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a, State Director 1 Yes 2 No Maryland | Frederick Walkersville 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21793 56 West Frederick Street U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: 3 ₩ Widowed 4 □ Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nurse's Aide Nursing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Lillian Mae Addison John David Shaff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 701 North Maxwell Avenue, Frederick, MD 21701 John B. Eury / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Mount Olivet Cemetery 7/29/2010 Frederick, Maryland Signate ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each life. Interval Between Onset and Death Immediate Cause (Final Block Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last physician a s the burial-1 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Day Vear Pregnant at time of death 1 Yes 2 Mg Unknown 9 Unknown been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Hospital or Attending Physician: The law 1 Yes 2 No To the Hospital or Attending Physician: "
within 24 hours after death.

To the Funeral Director. After this certific:
completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4/X Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No ☐ Accident☐ Suicide Investigation 6 
Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D43091 7-26-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hom Are Frederik MD 21701 MO Candi 801 31. Date filed (Month, Day, Year) 32. Registrar's Signature State are BASKAG. Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deat Physician/ 25 2010 Μ. 3:00 p.m. Susan Evans July Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospice House of St. Mary's St. Mary's Callaway 5. Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗶 F Days Hours Min 07/04/194 Country) 63 **Director** 258-76-1480 Kansas Usual Residence of Decedent or 28a-f show notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked of other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland St. Mary's Great Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 22221 Balsam Way 20634 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Force 1 Never Married 2 Married <u>م</u> 2 XNo Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Realtor Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Dorothy W. Johnston James L. Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Great Mills, MD20634 Debbie Dunlap/Friend Balsam Way, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Important: If it any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cre 07/28/2010 Charlotte Hall, MD Signation of Fineral Service Edward N. Br . Signatu 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Brinsfield M00052 22955 Hollywood Road, Leonardtown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Pitysician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Physician: The law equires that the death certificate be executed use as the burial-tran attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ò Month 5 Other (specify) the a 9 Unknown 9 Unknow signed by the Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 I Yes ¥o 3 ☐ Probably 4 ☐ Unknown een 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy perforn Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospice House Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\raisebox{.5ex}{$\Bigsigma}$  Other (Specify) ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Physis within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral directors. this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending Natural 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical ertifying Physician: To the \_est \_\_y knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the \_\_s of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Presumper: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

31. Date filed (Month Day, Year,

James

30. Name and address of person who compless

boyd

AUG 01

M.D

cause of Jean H., m 23a) (Type, Print)

41680

29c. License number

Miss Bessie Drive, Leonardtown,

29d. Date signed (Month, Day, Year)

20650

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 4:52am 2010 JULY Bell English /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical La Plata If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🗓 F Months Days Hours 237-30-8936 Director July 4, 1918 North Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Maryland Prince George's Brandywine 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 17306 Croom Rd. 20613 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: White 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Welch Lilly Parker ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 a Department of Health ar Important: If item 27 Is any Injury or other trau Lottie B. Seger/Daughter Croom Rd., Brandywine, MD 20613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Trinity Mem. Gardens | 08/03/2010 Waldorf, MD 22. Name and Address of Facility Brinsfield-Echols Funeral Home 21. Signature of Funeral Bervice Licensee 30195 Three Notch Rd., Charlotte Hall, MD 20622 ease, or complications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, lure. List only one cause on each line. 23a. Part 1. Enter the or eas shock, or heart of lure. Approximate Interval Between Onset and Death Immediate Cause ( al disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760 the attending physician Physician/Medical the 23c. If yes, outcome of pregnancy
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1 □Yes 2 □No 24a. Was an has autopsy performed? Yes 2 No certificate Division of Vital 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t 28d. Describe how injury occurred After Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 ☐ Homicide 29a. Certifier 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0026064

Corne

State Registr<u>ar</u> VIDYASAGAR
31. Date filed (Month, Day, Year)

AUG 0 3 2010

ated cause of death (Item 23a) (Type, Print) MD 10583 - THEODORE GREEN BLVD AND WHITE PLAINS, MD - 20695

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

		For State	Type or Print in Black State of Maryland	/ Depa		Health and		ygiene			
Physic /Medi		Registrar  1. Decedent's Name (First, Middle, Last Bettie R. Frey	)	001	imodic or	Death	2. Date of D Month July	Reg. No. peath 27 pay	2010 2010ar	32 im Sof 11:55	
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with the I	Funeral Director	10e. Street and Number 3160 Gracefield R			10f. Zip Code 2090	)4		_	en of What Cou ed Stat	-	
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To the within some some some some some some some some	M	29b. Signature and title of certifier	undle	2 RU	29c. Licen	se number	7	29d. Date	signed (Month,	Day, Year)	
		30. Name and address of person who care Eileen Gemmell, C	RNP 3160 Gracef	ield	Road Sil	ver Spri	ng, Mar	yland	20904	311-25-2	
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N Ta	ysicia s cert direct	To Be	examiner? 1 ☐ Yes 2 🛣 No	Hospital:	npatient 2 🗆	ER/Outpatien	Oth	ar:		5 Reside	nce 6 🗆 O	ther (Specify	1
ō	ng Ph fter thi ineral		27. Manner of Death  1 Natural 5 Pending	28a. Date o	· ·	28b. Time of injury	28c. Injur	y at		. Describe ho			
lon	tendii Jeath. tor: Ai the fu	Certificate:	2 Accident Investigat 3 Suicide 6 Could no	t he			M 1 🗆	Yes 2 No	_				
DIVISION	il or Al after of Direc		4 Homicide determine	28e. Place o	of Injury - At ho g, etc. (Specify)	me, farm, stre	et, factory, office		28f.	Location (Str City or Town,		ber or Rurai	Route Number,
-	To the Hospital or Attending Physician: The law requires that the death certific, within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 2 Medical Exa	hysician: To the be	of examination	and/or invest	igation, in my opini	on, death occur	rred at the	time, date and	place, and o	due to the ca	use(s) and manner stated.
	o the lithin 2 or the lomple	M	only one) 3 Certifying No. 29b. Signature and title of certifier	urse Practioner: To	o the best of my	knowledge, d	eath occurred at the 29c. Licens		nd place, ar		ause(s) and a		
	12+1		W W	Amato	Tel 11	10			42742			28, 2	
	(0,0		30. Name and address of person wh		of death (Item	23a) (Type, P	rint)	_ 7	7.7				
			Thomas Michael  31. Date filed (Month, Day, Year)				0 Georgi	a Ave.,	, was	ningto	n, DC	20307	
	Stat Registra		JUL 29 201		gistrar's Signat	ure fact	20						

			1 - For State Registrar		Maryland	/ Depa		t of H	ealth a		ental Hy		9	253	
	Physic	ian	1. Decedent's Name (First, Mic Geraldine	<sup>idio, Last)</sup> Keeli	ng	Fie	elds				2. Date of De Month	Day	Yeer	3. Time o	
>	/Medi Examii		4a. Fecility Name (If not institut	ion, give street and numi	ber)		4b. City,	Town, or	Location o	of Death	July 2	4 <sub>2</sub> 20	OLU County of Deat	5:15	A M
	LAdim	ici	Springbrook Ad				Silve						ontgome		
	Funeral Director		5. Social Security Number 513–12–3681	6. Sex 7 1 ☐ M 2 🛣 F	. Age (In yrs. Ias 86	st birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Bin (Month, Da 9/24/1	y. Year) 923		hplece (State buntry) ka, KS	or Foreign
	land ow		Usual Residence of Decedent 10a. State 10b. Cour	ty	10c. City,	Town or Lo	ocation			,. ,				10d. Inside C	City Limits
	a-f sh	ctor	MD Mont	gomery	Silv	er Sp	ring							1X Yes	2 □ No
	th with th 23a or 28	ai Director	10e. Street and Number 12325 New Ha	ampshire Ave	2		10f. Zip 209	Code 904					en of What Co ced Sta		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Example roughled at ODGE.	Completed by Funeral	11. Marital Status  1 □ Never Married 2 □ M. 3 ☑ Widowed 4 □ Divorce	If Yas Giva	es? ⊠No		Was Deced If Yes, spec			gin? (Spe , Puerto f	cify Yes or No Rican, etc.)		4. Race - Ame Black, White Specify: B1	e, etc.	
21215-0036	vithin 72 ho ne. han *natur	mpieted	(Specify only high Elementary/Secondary (0-12	ent's Education nest grade completed) ) College (1-4	lor 5+)		kind of wor DO NDT us	al Occupa rk done d se retired)	ition uring most	of workir	ng		d of Business/	Industry	-
d 2	filed v Hygie other t	Co	12 17. Father's Name (First, Middl	e, Last)		Homen	naker		18. Mothe	r's Name	(First, Middle,		nestic		
lan	Aental Aental rked c	To Be	Unknown								Keelin		<i></i>		
, Maryland	alth and h		19a. Informant's Name/Relatio Linda Fields	nship <i>(Type, Print)</i> (Daughter)			ng Address Tranci				Route Numbe			. ,	
Baltimore,	Pages 1 and of He not: If Item		20a. Method of Disposition  1			ce of Disponence					ate /2010		ation - City or		
Balti	permit. Departmit. Imports any inju		21. Signature of Funeral Service	elicensee .		22	. Name an	d Addres	s of Facility	Fort	Linco ad Bre	ln Fu	neral	Home	
	*		23a. Part1. Enter the disc e, shock, or heart failvire Li	or complications that caust only one cause on each	ised the death.	Do not ent	er the mod	e of dying	, such as	cardiac o	r respiratory ar	rest,		Approxima Interval Be	tween
	Physician /Medical		Immediate Cause (Fina disease or condition resulting in death)	_	ımonia									Onset and	Death
	Examiner			1000	as a conseque	nce of):									
	- N	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Office of The State		haria as a conseque	nce of):							-	-	
	and -transi	Examiner	that initiated events resulting in death) Last	0.	cinsons		ase								
760,	ate be executed hysician and he burial-transit	caiE			as a consequer	nce on:									
89	tificate ng phy as the		15 551111 5	d											
.O. Box	The law requires that the death certificat te has been signed by the attending phyage 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼ No 9 ☐ Unknown		h 2 ∏ Fetal de it at time of deat	eath 3	Ectopic pro					23	id. Date of deli Month	,	Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant condi	tions contributing to deal	th but not resulti	ng in the ur	nderlying ca	ause give	n in Part I.			obacco use	e contribute to	the cause of obably 4 🛭	
l Records,		Completed											death?	topsy findings completion of c	available cause of
Vital	Physician: Th this certificate ral director, pag	Be (	25. Was case referred to medic examiner?							of Death	(Check only o				
ŏ	Phys this	-: 70	1 Yes 2 XNo	Hospital: 1 _ Inp		VOutpatien		A Other	4.6 INUI		ne 5 🗌 Resid 8d. Describe h			city)	
0	Attending in death.	ation	1 XNatural 5 Pend	ing 28a. Date of (Month, tigation	Day Yeer)	Injury	м	Work'	?î es 2 □ N		50. D6301106 1	ow injury	occurred		
Division	s after death al Director; ad in by the	Certification:	3 ☐ Suicide 6 ☐ Could deter	mined 286. Place of	Injury - At home , etc. (Specify)	e, farm, stre	et, factory	. office		2	8f. Location (S City or Tow		Number or Ru	ral Route Nun	nber,
	To the Hospital or Al within 24 hours after of To the Funeral Directompletely filled in by	edical	29a. Certifier 1 X Certify (Check only one)	ing Physician: To the be I Examiner: On the basi and manner	s of examination	edge, death and/or inv	occurred a restigation,	at the time in my opi	o, date and nion, deat	place, a	nd due to the o d at the time, o	ause(s) a date and p	nd manner as lace, and due	stated. to the cause(s	5)
	Tot Com	Σ	29b. Signature and title of certif	Plas	30	•	290	D454					signed (Month / 27 / 20 1		
	0-		30. Name and address of perso						_						
	Sta	te	Yeheyis Negus: 31. Date filed (Month, Day, Yea	Sie, MD 111	1 Sprir	θ ,		Suite	214	Si	lver Sp	ring	, MD 2	23185	
e	Registr		JUL 2 9		m B.	ja	Kel								
DHA	AH 17 Rev 1/20	-													

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 26. 2010 Josie Giordano Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Silver Spring Holy Cross Hospital Montgomery 7. Age (In yrs. last birthday) If Under Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funera 1 □ M 2 **X** F August 31,1920 Massachusetts Director 212-34-4190 89 Usual Residence of Decedent ifled within 72 hours and tall Hygiene.
ed other than "natural", or items 23a or 28a-f show
the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Directo Maryland Montgomery Silver Spring 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 2500 McHenry Drive 20904 u.s.A 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces ğ 1 Never Married 2 Married ☐ Yes 2 🗓 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Garment nd Mental Hygier marked other t Inspector 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fill thent of Health and Mental rant: If item 27 is marked or Frank Incrapera Mary Baragona 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2500 McHenry Drive. Silver Spring, Maryland 20904 Department of Health Important: If item 27 any injury or other to Frank G. Giordano - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lincoln Crematory 07/30/2010 | Brentwood, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee |11800 New Hampshire Ave., Silver\_Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Exami physician and s the burial-transit Acute Myocardial Infarction that initiated events Due to (or as a consequence of) requires that the death certificate be exec resulting in death) Last Completed by Physician/Medical P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Pregnant at time of death 1 ∐ Yes 2 M 9 ☐ Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Severe Aortic Stenosis Records, 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Acute Renal Failure 24a. Was an spital or Attending Physician: The law rours after death.

eral Director: After this certificate has brilled in by the funeral director, page 2 sl performed? Yes 2 No Cardiogenic Shock 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No ပ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 24 hours a Hospital Medical 🛮 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

1834 M

10d. Inside City Limits

Caucasian

Approximate

2 🗌 No

2010

29d. Date signed (Month, Day, Year)

Onset and Death

1 Tes 2 X No

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

To the Within 2

DHMH 17 Rev 7/2009

Satyam Ashvinkumar Shah, MD, 1500 Forest Glen Road, Silver Spring, MD

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D68096

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Rose Evelyn Giles July 27, 346 PM **Physician** 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Apt 505 Harford 100 Revolution Street Havre de Grace | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 0.8 - 2.0 - 1.929 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 👿 F 80 217-24-2938 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Exercines must be notified at Harrond Havre de Grace Maryland Director 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States of America 21078 100 Revolution Street Apt. 505 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 □Yes 2 No Specify ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) nd Mental Hygiene. marked other than Food Service Worker Food Service 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) Be Olive Deckman Henry Raymond Burkins ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 839 Verona Lake Drive, Weston, Florida 33326 19a. Informant's Name/Relationship (Type. Print) Rebecca Hogg (daughter) Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harford Mem. Gardens 07-31-2010 Aberdeen, Maryland 22. Name and Address of Facility Zellman Funeral Home, P.A. 21078 21. Signature of Tuperal Se 123 S. Washington St. Havre de Grace, Maryland 23a. Part1. Enter 1, of isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ustali /Medical Due to (or as a consequence of): Examiner nosclar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: for use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) the detached 9 Hinknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ş pe & No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has autopsy performed? Yes & No certificate 1 ☐ Yes 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 24 hours after deat Funeral Director: the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State AUG 0 2 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25314 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 5:54 p Edward July 3 and 3 Thomas Garrison Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's St. Mary's Hospital Leonardtown 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Country) Maryland 1 🛣 M 2 🗆 F Months Days Hours Min. 12/02/1944 Director 65 215-44-4531 Usual Residence of Decedent 28a-f shov 10b. County of Health and Mental Hygiene. item 23a or 28a-f shor item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2x No Maryland St. Mary's Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20659 39224 Golden Beach Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, 1 ☐ Yes 2 🔣 No If Yes, Give Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Glass Company 12 Glazier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I-Important: If item 27 is marked of any injury or other travers ပ Garrison Margaret Anderson Richard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 39224 Golden Beach Rd., Mechanicsville, MD 20659 Gail J. Garrison/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🗆 Burial 2 🛛 Cremation 3 🗀 Removal from State Charlotte: Hall, MD Brinsfield-Echols 4 Donation 5 Other/Specify 08/01/2010 Sign 22. Name and Address of Facility
Brinsfield-Echols Funeral Home, P.A.
30195 Three Notch Rd., Charlotte Hall, MD 20622 Edward N. Brinsfield, M00052 Jr. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Ventriular standstill disease or condition resulting in death) secondary Medical Due to (or as a consequence of): **Examiner** years cardianyipath Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a consequence of: To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that the death certificate be executed Hypertension Dulmonery that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical renol 4 cms 5 tage Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year 5 Other (specify) Month Day Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician; The law requires 24 hours after death. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? After this certificate 1 🗌 Yes 2 🗌 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 은 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Manner of Death

Natural 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred injury 5 Pending 2 Accident Investigation after death Director: / 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital or within 24 hours a To the Funeral D Medical 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practice or To the best of my knowledge death accounted to time. Satisfied and place, and Subject the nurse (s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Garrison

State Registrar Lars

Ranhart 31. Date filed (Month, Day, Year) Registrar's Signature AUG 01

Bax

524

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Po

0068540

20650

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 430 PM AUGUST 2010 Gardiner Doris Esther /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** CHARLES LA PLATA CIVISTA MEDICAL CENTER Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Hours Min 1 ☐ M 2 ☐ F Months Days 84 Yrs 22, Maryland Director 215-26-0097 1925 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√No ral", or items 23a or 28a-f sl Exeminer naust be notified Director Charles Mechanics ville Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20659 14010 Edward Gardiner Rd. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 🔯 No Specify ò Specify: White 3 X Widowed 4 □ Divorced Year or Dates "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Maryland 2121 Elementary/Secondary (0-12) 12 other than College (1-4or 5+) Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be finance and Mental F is marked Henry Bowie ဂ္ Arlene Thompson St.Clair 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health item 27 14003 Edward Gardiner Rd., Mechanicsville, MD 20659 <u>David Alan Gardiner/Son</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition ᇹ 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department o Important: If i any Injury or once. = 5 Peter's Cemetery 08/09/2010 Waldorf, MD 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. 21. Signature of Funeral Service License 30195 Three Notch Rd., Charlotte Hall, MD 20622 M00817 Approximate Interval Between Onset and Death 23a, Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequ Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician a s the burial-1 Box 68760, Physician/Medical attending p IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) signed by the a Ö 9 Unknown 9 Ulnknown o, Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 4 Unknown 3 Probably 1 ☐ Yes 2 ☐ No should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 □Yes 2 □No 2 No 1 ☐ Yes Division of Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 No 2 XER/Outpatient 3 □ DOA 1 Inpatient Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No 124 hours after death.

Re Funeral Director: A pletely filled in by the fu investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in my opinion, doubt account of the cause(s) and manner as stated. 29a. Certifie within 24 hou

To the Fune

completely fi Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and 2010

State Registrar

DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, Year)

Post office Rd,

State of Maryland / Department of Health and Mental Hygiene Michelle Elizabeth Humanick 1. For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day July 25, 2010 Michelle Elizabeth Humanick 1623 hrs **Medical Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's 11000 Block of Rhoda Island Ave. College Park 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** 157-66-8669 Months Davs Hours Director Mar.17,1966 1 M 2 X F 44 NewwyJersev Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b Count Prince George's 1 Yes 2 No Marvland College Park 28a-f show 23a or 28a-f short notified at once. timore, MD 21215-0036

it. Pages I and 2 should be filed within 72 hours after death with the Maryland trent of Health and Mental Hygiene.
reant: If item 27 is marked other than "natural", or items 23a or 28a-f sho y or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7316A Radcliffe Drive 20740 United States Funeral 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: White þ or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 1-4 Graphic Designer University of Maryland 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Peter Joseph Humanick Helen Urban 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Clayton Gump -husband 7316A Radcliffe Drive College Park, Maryland20740 20c. Location - City or Town, State Baltimore, I 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 1 X Burial 2 Cremation 3 Removal from State St. Mary's Cemetery 7/31/2010 Salem, New Jersey Important 4 Donation 5 Other Specify: Bonand Wes Bongwardt Funeral Home, 21. Signature of Funeral Service Lies 4400 Powder Mill Road Beltsville, Maryland20705 23a. Part I. Enter the disease, or comcations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a Multiple Blunt Force Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) icate has been signed by the attending physician and page 2 should be detached for use as the burial - transi certificate be executed Physician/Medical UNPENDED **AMENDED** Box 68760, IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, P.O. र्घ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has death? performed' ✓ Yes 2 No 1 Yes 26.Place of Death (Check only one) Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical æ Other<sub>4</sub> Hospital: 1 examiner? Nursing Home 5 Residence 6 🗸 Other: Scene Inpatient 2 ER/Outpatient 3 1 V Yes ို 2 No 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Tree fell on subject's car FOUND: Division 1 Natural 1 Yes 2 ✓ No Pending To the Hospital or Attend within 24 hours after death. To the Funeral Director: the Certificati Jul 25, 2010 1544 hrs 2 🗸 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 11000 Block of Rhoda Island Ave., College Park, MD determined (Specify) Local Street 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10 July 26, 2010 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 artes 31. Date filed (1991), D (1991) 2010 32. Registrar's Signature State Energy

Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ <sup>Day</sup> 2010 July Opa1 Houston 19, 11:45a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6020 Sargent Road, Apt. Hyattsville Prince George's If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) **ov.** 6, 1944 1 □ M 2 🛣 Hours Min. 524-58-3592 Director 65 Yrs. Nov. Pueblo, Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 X Yes 2 ☐ No MD Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6020 Sargent Rd. #2212 20782 United States of America items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give ural", or iterr I Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: "natural", 3 Widowed 4 Nivorced Specify: Completed **Black** Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Department of Labor <u>Secretary</u> Be should be filed permit, Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Storey Pearl Storey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maya Houston/daughter 1827 A St. NE Washington, DC 20003 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Chesapeake Crematory | 08/02/2010 | 4 Donation 5 Other (Specify) Beltsville, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McGuire Funeral Service Inc. Usburi 7400 Georgia Ave. NW Washington, DC 20012 23a. Por 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Pnysician/ Cardiopulmonary Arrest Medical resulting in death) Due to (or as a consequence of Examiner Hypertensive Vascular Disease Sequentially list conditions, if any leading to in neglect cause. Enter Underlying Cause (Disease or linjury Disk to for as a consecuence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director: page 2 should he dehadred for the funeral director. Exam that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Renal Failure 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗡 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 🗌 Yes 2 🗌 No 1 X Natural 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. City or Town, State) Medical 29a. Certifier \*\*Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: to the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signat 29c. License number 29d. Date signed (Month, Day, Year) MD17267 7/21/2010 30. Name and address of person who completed cause of em 23a) (Type, Print) 1208 Crittenden St. NW Washington, DC 20010 Dr. Dana McGinty 31. Date filed (Month, Day, Year) JUL 29 201 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>010</u> Physician/ Month July Daniel A. Honig 2:49 p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5630 Wisconsin Avenue #704 Chevy Chase Montgomery Birthplace (State or Foreign Country)
 NY If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours 1 X M 2 D F 09/06/1932 77 Director 261-40-3434 Usual Residence of Decedent If item 27 is marked other than "natural", or items 23a or 28a-f shov or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Completed by Funeral Director 1 X Yes 2 □ No MD Montgomery Chevy Chase 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 5630 Wisconsin Avenue #704 20815 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces' Black, White, etc. 1 Never Married 2 🙀 Married 2 No 1950-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced White 1952 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and 2 should be filed within 7. Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Attorney Law Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Herman Honig Henrietta Griff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Honig, wife 13335 Verdun Drive, Palm Beach Gardens, FL 33410 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 Donation 5 Other (Specify) Star of David 07/30/2010 West Palm Beach, FL PDANZANSKY-GÖLDBERG MEMORIAL CHAPELS, INC. MO1255 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ a. Lymphoma, Non-Hodgkin's vears Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last igned by the attending physician and be detached for use as the burial-transi Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ Fetal deat☐ Pregnant at time of death 3 Cther (specify) in the past 12 months?

1 Yes 2 No Day Month Year 9 Unknown 9 Unknown been signed by Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? Atrial Fibrillation 24a. Was an Jas autopsy performed? To the Funeral Director: After this certificate of completed filled in by the funeral director, page 2 🔀 N Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 🕱 No 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

20

7758 Wisconsin Avenue #211, Bethesda, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Roy Fried, MD,

29

31. Date filed (Month, Day, Year)

D34590

July 27, 2010

20814

State Registrar

DHMH 17 Rev 7/2009

Box 68760

P.O.

of Vital

31. Date filed (Month. Day, Year)

William S. Vaughn,

32. Registrar's Signature

III

3060 Mitchellville Rd, Ste 211, Bowie, MD 20716

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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	•	State Registrar					tificate of L			Reg. No.	010	25320	
Physicia Medic		Decedent's Name (First, Middle, Last)     Audrey P. Hinkelman								2. Date of Death			
Examin		4a. Facility Name (if not institution, give street and number)					4b. City, Town, or Location of Death Ellicott City			4c. County of Death			
Funeral			Ivy Manor Care  5. Social Security Number   6. Sex   7. Age (In yrs. la				If Under 1 Year		Howard  8. Date of Birth  9. Birthplace (State or F			nplace (State or Foreign	
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	Director	MD Howard  10e. Street and Number			Columbia 10f. Zip Code				10g. Citizen o	£ \A/bat Car	1 Yes 2 XNo		
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tems er mu	Funeral	11. Marital Status		12. Was Decedent	Ever in U.S		Was Decedent of H	ispanic Origin? (Sp	ecify Yes or No-		ace - Ameri		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inmportant if firem Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by I	1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ 1 ☐ Yes 2 ☐ 1 ☐ Yes 2 ☐ 1 ☐ Yes 3 ☐ 1 ☐ Yes 4 ☐ 1 ☐ Yes 3 ☐ 1 ☐ Y			No		f Yes, specify Cuba 1 ☐ Yes 2 🙀 No	an, Mexican, Puerto Specify:	Hican, etc.)		Black, White, etc. specify: White		
		15. Decedent's Education (Specify only highest grade completed)				(Give	dent's Usual Occup kind of work done	ation during most of work	ing	16b. Kind of	16b. Kind of Business Industry		
	Con	Elementary/Seconday (0-12) College (1-4 or 2			5+)		ONOT use retired) cutive Se	cretary		Federa	1 Gov	ernment	
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	욘	Elmer	Elmer E. Ping					L. Bart	. Barton				
		· ·					ailing Address (Street and Number or Rural Route Number, City or Town, 04 B Avalanche Way Columbia, MD 2						
or oth		20a. Method of Disp		X Removal from State	C	emetery, crer	sition (Name of natory or other plac	ce)	Date	20c. Location			
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Depar Impo any ir		21. Signature of Fu	neral Service Licer	M010	44	22 /11	2. Name and Addre	ss of Facility Har Clumbia I	cry H. W	itzke'	s Fam	ily F.H.Inc. MD 21043	
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hysician/ Medical	Examiner	Immediate Cause ( disease or condition resulting in death)		a	FROS	c cerd	TIC CAP	LOIOVA SCU	LAR B	)। ४८७१ ऽ	ح ا	7 ENCS	
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within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1					☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of delivery Month Day Year			
signed by	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying car					nderlying cause giv	en in Part I. 23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown					
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ath. r: After e fune	icate	1 ■ Natural 2 □ Accident	5 Pending Investigation	(Month, Da	nth, Day, Year) injury work?  M 1 ☐ Yes 2 ☐ No								
after dea Director I in by the	Certificate:	3 Suicide 6 Could not be								If. Location (Street and Number or Rural Route Number, City or Town, State)			
24 hours Funeral	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one)  3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
withir comp	2	29b. Signature and the of certifier						29c. License number 29			29d. Date signed (Month, Day, Year)		
		1 Clar Mo					D5/860 July				30 2010		
6		only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month) Pay, Year)  32. Segistrar's Signature  33. Date filed (Month) Pay, Year)											
Stat Registra	e ir	31. Date filed (Monti	JUL 30 2	2010 32. Fegistr	ar's Signat	ure	aked						
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State 31. Date filed (Month, Cay, Year)
Registrar

Assistant Medical Examiner

32. Registrar's Signature

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

August 4, 2010

30. Name and address of person who completed cause of death (Item 23a)

Patricia Aronica-Pollak MD.

			For State Registrar	State of M	larylan	-	rtment of F tificate of D	Health and N Death	Mental Hy	giene Reg. No.2	010	25322		
1. Decedent's Name (First, Middle, Last)									2. Date of De	ath		3. Time of Death		
Pi									Month July					
	4a. Facility Name (if not institution, give street and number)						4b. City, Town, or Location of Death			4c. County of Death				
	FREDERICK MEMORIAL HOSPITAL  5. Social Security Number 6. Sex 7. Age (In yrs.)					FREDERICK  s. last birthday)   If Under 1 Year   If Under 24 H			FREDERICK  8. Date of Birth  9. Birthplace (State o.					
	ineral rector		5. Social Security Number 6. Sex 1 M 2 <b>X</b> F 7. Age			Yrs.	Months Days			i, 1967	9. Birthplace (State or Foreign Country) Mary Land			
		ű.	Usual Residence of Decedent						<u> </u>					
ryland	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy rijury or other traumatic event, the Medical Examiner must be notified at once.	ctor	10a. State									10d. Inside City Limits		
ie Ma		Director	10e. Street and Number			DIGIIS	10f. Zip Code			10a Citizon	of What Cou	1X Yes 2 □ No		
with th			312 East D.	Street		21716					d Stat			
eath v		Funeral	11. Marital Status	12. Was Decedent	Ever in U.S		as Decedent of Hi	ispanic Origin? (Spe	ecify Yes or No-	14.	Race - Americ	can Indian,		
ffer d	, or i	by	1 Never Married 2 Married Armed Forces 1 1 Yes 2 M No If Yes, Give				Yes, specify Cuba		, Mexican, Puerto Rican, etc.)  Specify:		Black, White, etc. Specify: White			
<b>Z13-0036</b> in 72 hours after e.	atural sal Ex	Completed	3 Widowed 4 Divorced Year or Dates.											
<b>7</b> 72 h	an "na Medic	mpl	(Specify only highest of	F.()	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind (	of Business In	dustry			
withir giene	er the		Elementary/Seconday (0-12)	5+)		of Perso	U.S. Government							
filed tal Hy	event	To Be	17. Father's Name (First, Middle, Last)						(First, Middle, Maiden Surname)					
Janen:	narke	۲	Dennis Eugene					Glori		Hines				
Maryland 2 should be filed th and Mental H)	27 is r traun		19a. Informant's Name/Relationship		-	ss (Street and Number or Rural Route Number, City or Town, State, Zip Code)  D. Street / Brunswick , Maryland 21716								
and Heal	item other		George F. Hawes  20a. Method of Disposition	s, 111/5poc	20b. PI	ace of Dispos	sition (Name of		Date		ion - City or To			
mo	nt: If i	Ų	1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		, I		atory or other place lle Union		/2010		•	,Virginia		
<b>baltimore,</b> permit. Page 1 and Department of Hee	porta y inju ice.		21. Signature of Funeral Service Lice					ss of Facility Sta						
മ ഉ	트등등		Daymond	Feler	ein	/ 11	00 N.Map	le Ave./	Brunsw	ick, M	D 217			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line.  Approximate Interval Between											
	ician/ edical	1	Immediate Cause (Final disease or condition a. hy poten son											
	miner		Due to (or a. a. a. nsequence of):											
		ner	Sequentially list conditions, if any, leading to immediate Due to (or as Lonsequente of):											
inted	ransit	tami	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events  C. Rengl +a U											
э өхөс	ilan ar urial-t	edical Examiner	resulting in death) Last  Due to (or as a consequence of):											
ate be	physician and s the burial-transit	edic	La <u>Coaquiopalhy</u>											
oo / Sertifica	nding ise as	Ž/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnan	icy				234	. Date of deliv	env		
death c	d for L	Physician/M	in the past 12 months?  1  Yes 2  No	2 ∐ Fetal at time of de	Fetal death 3   Ectopic pregnancy so death 5 Other (specify)				Month		Day Year			
at the	by the tacher	hys	9 Unknown 9 Unknown											
s that	gned be de		Part II. Other significant conditions contributing to death but not resulting in the under Byeash Can cer					underlying cause given in Part I.			23e. Did tobacco use contribute to the cause of death?  1  Yes 2  No 3  Probably 4X Unknown			
ros equire	seen s nould	eted	12 vedit milose									,		
Vital necords,	nas r je 2 sl	Completed by							24a. Was auto	psv	4b. Were auto prior to co death?	psy findings available mpletion of cause of		
בֿ ב <u>ַ</u>	mcate or, paç		25. Was case refirmed to medical	1		<del></del>	26 Pla	ace of Death (Check		ormed? 2 <b>X</b> No	1 🗌 Yes	2 🗆 No		
VII.a	s certi	To Be	25. Was case r. * -3 d to medical examiner?  1									•)		
5 E	neral neral		27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of inju	iry :	28b. Time of injury	ne of 28c. Injury at 28d. Describe how injury occurred							
or Attending Pl	To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	ifica	2 Accident Investigation			M 1 ☐ Yes 2 ☐ No			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
or At		Certificate:												
spital	i filled		29a. Certifier 1- Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.									d.		
he Ho in 24 l	ne Fui pletec	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to only one)  3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner.								due to the ca	use(s) and manner stated.		
To th	E 00		29b. Signature and title of certifier		29c. License number 29d. Date signed (Month, Day, Year)									
			D0063256 July/25/2010								12010			
8 Ramani Nokku / 400 West 7th St/ Frederick, Maryland 21701								•						
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature														
R	egistra		JUL 2	( ZU U ) CA	MARCHAL.	13.	Jan Service		<u></u>					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July John Holliday Jr 2010 6:55 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Future Care Chesapeake Arnold Anne Arundel Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 X M 2 □ F Days Hours Feb 26 1932 Maryland **Director** 220-22-7987 78 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho dical Examiner must be notified at 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? Funeral 111 Dominoe Rd. 21401 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 Divorced Black Year or Dates.1952-54 permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Naval Research College (1-4 or 5+) Elementary/Seconday (0-12) 12th 0 Security Officer Center Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Holliday Sr Alice A. Harrod 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cecelia M. Derrick(Daughter) 3237 Henson Ave Annapolis, Md. 21403 20a. Method of Disposition 20H Place of DSpreame of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Memorial Gardens 7-28-10 Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) Windowe Records of Paris Sons Mortuary, P.A. . Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 LeeseM098 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final 50 P513 Physician/ disease or condition resulting in death) Medical Due to lor as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant a Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an After this certificate has funeral director, page 2 s autopsy 25. Was case referred to medical examiner? within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) 2 3 No Certificate: To 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Manna of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury Natural 5 Pending Accident 4 1 Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined Medical 29a. Certifier Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the P within 2 To the P only one) 29b. Signatur

State Registrar DHMH 17 Rev 7/2009 twy W. Wersville MD 21108

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print)

Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ EANNE Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Arbor at Baywoods Annapolis Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Indiana 8. Date of Birth **Funeral** 303-24-5739 1 □ M 2 🔽 F 86 Months Days Hours Min 4971071924 Director Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10b. County 10a. State 10c, City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7101 Bayfront Drive 21403 USA within 72 hours after death 12. Was Decedent Ever in U.S 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. β 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 TNo Specify. Specify: Completed 3 K Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Executive Secretary Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gaston Estep Edna Joans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5227 Herzell Woods Ct, Fairfax, VA 22032 Mary Steelman - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State Baltimore Crematory 7/29/2010 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility John M Taylor Funeral Home 147 Duke of Gloucester St, Annapolis, MD 21401 en1. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician, ment disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ 1 Live Birth
4 Pregnant
9 Unknown in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24a, Was an 24b. Were autopsy findings available autopsy performed? Yes 2 X No prior to completion of cause of death? 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 No ၉ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred Ratural Accident injury 5 Pendina Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier retifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signa re and title of certifie person who completed cause of

DHMH 17 Rev 7/2009

State Registrar Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Edward Hall III July 25<sup>Day</sup> 2010 10:30 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Anne Arundel **Examiner** Sunrise Assisted Living Annapolis 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year) 1916 220-22-0390 1 🕱 M 2 🗆 F Months Days Min April 26, 94 **Director** Maryland Usual Residence of Decedent 28a-f shov 10a State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Directo Maryland Anne Arundel Annapolis 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 905 Mastline Drive 21401 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 2 Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. Land Surveyor Surveying Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
Margaret Stubbs Edward Hall, Jr. ٥ permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev 19a. Informant's Name/Relationship (Type, Print)
Alice R. Hall/wife 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 905 Mastline Drive Annapolis, Maryland 21401 905 Mastline Drive Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Baltimore Crematory 1 Burial 2 X Cremation 3 Removal from State Baltimore, Maryland :7/28/2010 4 Donation 5 Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licenses Myden T. Klobax 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Congestive Heart Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir death certificate be executed Cause (Disease or iinjury that initiated events the attending physician and hed for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2XXNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an cate has page 2 s this certificate **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be Assisted Livina examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospital: 2XXNo 1 🗌 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d, Describe how injury occurred Hospital or Attending injury work? 1 ☐ Yes 2 ☐ No XX Natural To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun 5 Pending Investigation 2 Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 XX ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the pass of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Praction of To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

Box 68760

Records,

31. Date filed (Month, Day, Year) 32. Registrar's Signature pare

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10

only one

29b. Signature and title

Dr. Jon Llowe

29c. License numbe

2009 Tidewater Colony Drive Annapolis, Maryland

D0018529

29d. Date signed (Month, Day, Year)
July 27, 2010

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For St State Registrar	ate of Maryland /	•	rtment of He tificate of De		,	giene Reg. No	2010	25326
	Physicia	n/	Decedent's Name (First, Middle, Last)     MARY ELLEN JONES					2, Date of Dea	ath		3. Time of Death
	Medic Examin	al	4a. Facility Name (if not institution, give street a	and number)		4b. City, Town, or L	ocation of Death	07/21/		County of Death	2:05 A M
			Maple Ridge Group Ho			Rockville			Mo	ntgomer	У
	Funeral Director		5. Social Security Number  248-26-5407  Usual Residence of Decedent	7. Age (In yrs. last bii	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day 02/26/	1 1920	9. Birth Cour	place (State or Foreign ntry) SC
	rland f show d at	tor	10a. State 10b. County	10c. City, Tov	wn or Loc	ation					10d. Inside City Limits
	ne Man or 28a- notifie	Director	MD Montgomery  10e. Street and Number	Rockvi	ille	10f. Zip Code			10 011		1 🗆 Yes 2🗶 No
	th with the ms 23a comust be	Funeral	15908 Maple Ridge Co			20853			USA	zen of What Cou	ntry?
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married 1	as Decedent Ever in U.S. med Forces? Yes	lf.	as Decedent of Hisp Yes, specify Cuban, ☐ Yes ② No	panic Origin? (Spe , Mexican, Puerto I Spec <i>ify:</i>	cify Yes or No- Rican, etc.)		14. Race - Americ Black, White, Specify: Bla	etc.
15-0	72 houl "natu ledical	Completed	15. Decedent's Educatio (Specify only highest grade con		(Give ki	ent's Usual Occupat ind of work done du	ion ring most of worki	ng	16b. Kin	nd of Business In	
212	within giene. er thar the N		Elementary/Seconday (0-12) Co	llege (1-4 or 5+)		NOT use retired)			Air	Force B	Base
and	oe filed antal Hy ced oth	To Be	17. Father's Name (First, Middle, Last)  James Aaron Cureton			- 1	18. Mother's Name Susie Ow		Maiden Si	Gurname)	
aryl	should band Me is mark		19a. Informant's Name/Relationship (Type, Prin			Address (Street an	nd Number or Rura	Route Number			Code)
e, ⊠	and 2 s Health em 27 ther tra		Renee Pumphrey - gra			lholland ition (Name of					0
Baltimore, Maryland 21215-0036	Page 1 nent of int: If it		1 🔀 Burial 2 □ Cremation 3 🛣 Remove 4 □ Donaton 5 □ Other (Specify)	al from State cemete	ery, crem	atory or other place) Nat'l Cer	)	)ate /10		cation - City or To ington ,	-
Balt	permit. Departr Imports any injs		21. Signatur of Funeral Service Licen	Lucus	22.	Name and Address  N. Wash	of Facility Sn	owden F	uner	al Home	
	Physician/	8 8	23a. Part 1. Enter the disease or complication shock, or heart failure. Ust only one caus Immediate Cause (Final disease or condition	is that caused the death. Do e on each line.							Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a consequence	of)	REGIST	Ganc	2/			1-146
	nsit 35	Examiner	Sequentially flet conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a consequence	of):	SAC 1	9 11 1				<del>4</del> <del>4</del> <del>4</del> <del>4</del>
_	icate be executed i physician and s the burlal-transit		that initiated events c c	Due to (or as a consequence	of):						
8760	tificate ng phys as the	Medical	IF FEMALE:								
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	he Hospit in 24 hour he Funera pleted fille	Medical	29a, Certifier (Check only one) 1 Certifying Physician: 2 Medical Examiner: On Certifying Nurse Practical Control on the Certifying Nurse Practical Control on the Certifying Nurse Practical Control on the Certifying Nurse Practical Control on the Certifying Nurse Practical Control on the Certifying Nurse Practical Control on the Certifying Nurse Practical Control on the Certifying Physician: 1 Certifying Physic		or investig	gation, in my opinion,	, death occurred at	the time, date ar	nd place, a	and due to the ca	use(s) and manner stated.
	To the common of		29b. Signature and title of certifier	On-		29c. License n	number 679	2	29d. Date	signed (Month,	Day, Year)
	1		30. Name and address of person who complete	CRAP 1180	DI	CAPLS	10,7024	s silve	Jou	m Mr	10Pas
	Stat Registra	e ir	31. Date filed (Month, Day, Year)  JUL 29 2010	32. Registrar's Signature	back	J.			7	(	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ernestine Christine Jones Day July 2010 Year 10:18A M 19 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Southern Maryland Hospital Prince Georges Clinton ( ) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2🗶 Days 04/04/1946 579-56-1041 Director Virginia Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director DC Washington 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3346 C Street SE 20019 ŪSA filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black "natural", Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Farmer Se1f Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herman Hargroc Helen Coleman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Latief/ Daughter 2052 Davis Ct. Waldorf, MD 20602 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Important: If it any injury or c cemetery, crematory or other place) 1 Burial 2 A Cremation 3 Removal from State Riverdale MD Riverdale Crematory 4 Donation 5 Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility Washington, DC 2 Street Northeast 20019 Dunn&Sons 5635 Eads 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on experime. Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Examiner Sequentially list nonclining if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran Due to (or as a co resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) been signed by the atte should be detached for in the past 12 months? Day Year Pregnant at time of death Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed neral Director: After this certificate I filled in by the funeral director, page 2 No Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 잍 2 | No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural injury 5 Pending work' 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Number Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year

Registrar

State

ANHAM

GOOS LUCK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are tegible State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ Isabeth Jones Julv 21 5:30 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore 5. Social Security Number unk 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
NOV 21, 1920 Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF Months Days Min. Director 89 Nov Tennessee Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 X No Maryland Anne Arundel Meade 6 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a 7625 Carr Circle 20755 United States death \ 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian "natural", or ģ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 X Widowed 4 ☐ Divorced Specify: African—Americah Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Secretary State Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Roy Fly Deloch Hattie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is Trust Palmer/granddaughter 7625 Carr Circle Ft. Meade, Maryland 20755 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date unk cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory Woodbine, Maryland of Funeral Service Lie Sign Ging Home Cremation Service P.O. Box 784 M00957 Beverly L. Heckrotte, P.A. 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death MALICATIONS Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinced by the control of the cont physician and the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death signed by the at d be detached for 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 Yes Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending injury work?
1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

State Registrar

Medical

29a. Certifier

(Check

CANIENE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1M

Registrar's Signature

OBBROWN

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D64395

6701 N CHAPLES ST. 8NITE 4105 BALTIMENE IND 21204

JULY 21, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State of Marylan	d / Depa <i>Cer</i>	artment of F <i>tificate of L</i>	lealth and N Death	ental Hyg/ ا	giene Reg. No. 20	10	25330
			1. Decedent's Name (First, Middle, Last)					<ol><li>Date of Dea</li></ol>	ith		3. Time of Death
	Physicia Medic		Audrey Marie John	son				July 30		Year	4:20 a.mM
	Examin	er	4a. Facility Name (if not institution, give stree	ŕ		4b. City, Town, or	Location of Death		4c. County of		
	Funeral		Taylor Farm Assiste  5. Social Security Number 6. Sex	d Living    7. Age (In yrs. Ia	st birthdav)	Bushwoo If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	St. Ma		lace (State or Foreign
	Director		494-42-3695 <sup>1 □ M</sup>	<sup>2</sup> XF 69	Yrs.	Months Days	Hours Min.	(Month, Day 09/04/1	, <sub>Year)</sub> .940	Counti [11in	rv)
	show dat	_	Usual Residence of Decedent  10a. State 10b. County	10c City	, Town or Lo	cation				11	Od. Inside City Limits
	arylar a-fst fied a	Director	Maryland St. Mary's	ĺ	ywood	Julion .					1  Yes 2 No
	or 28	۵	10e. Street and Number	HOII	.ywoou	10f. Zip Code			10g. Citizen of W	hat Count	try?
	with s 23a ust b	Funeral	42555 Kenneth Court			20636			United S	State	:S
	death item			Was Decedent Ever in U.S Armed Forces?		Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- America	
36	ye 1 and 2 should be flied within 72 hours after death with the Maryland to f Heath and Mental Hygiene. It of Heath and Mental Hygiene. It mem 27 is an artered than "natural", or items 23s ar 28a-f sho or other traumatic event, the Medical Examiner must be notified at or other traumatic event, the Medical Examiner.	d by	0   Widowed   4	Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates.		☐ Yes 2 🛚 No			Specify:	Whi	
ğ	hours natur lical E	lete	15. Decedent's Educat	ion		lent's Usual Occup			16b. Kind of Bus		
21215-0036	nin 72 ne. han "	Completed	(Specify only highest grade of Elementary/Seconday (0-12)	College (1-4 or 5+)	life. D	kind of work done o O NOT use retired)	-				
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Maryland	be file antal h ked o c eve	일	17. Father's Name (First, Middle, Last)  Joseph C Schimp	f			18. Mother's Name				
ary	ould Ind Me		19a. Informant's Name/Relationship (Type, F		19b Mailir	ng Address (Street a				ate Zin C	ode)
ž	d 2 sh alth a n 27 is er trau		John A. Johnson/Hus	band	1	Kenneth			_	0636	
ore,	ge 1 an nt of He : <b>If iten</b> or othe		20a. Method of Disposition 1 ☐ Burial 2 🎛 Cremation 3 ☐ Rem	20b. Pl	ace of Dispo	sition (Name of natory or other plac	e) 1	Date	20c. Location - 0	City or Tov	wn, State
Baltimore,	Page 1 tment of l tant: If it jury or o		4 Donation 5 Other (Specify)	Ovar Horri Otato	nsfie1	d-Echols	Cre 07/3				
Baj	permit. Page Department or Important: If any injury or once.		21. Signature of Funeral Service Censee			. Name and Addres					
		-	23a. Part 1. Enter the disease, or complicat	eld, Jr. MO( ons that caused the death						MD	20650 Approximate
	nysician/		shock, or heart failure. List only one ca Immediate Cause (Final	use are ch line.	4-15	1)					Interval Between Onset and Death
	Medical		disease or condition resulting in death)	Due to (or as a consequence	ence of):					+	
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	sit sit	Examiner	if any leading to immediate cause. Enter Underlying Cause (Disease or linjury	Divido (or as a do raigu	ente on						
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876	tificate ng ph	Med	IF FEMALE:								
9 X	eath certifice attending p	ian/	23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregnar  1 ☐ Live Birth 2 ☐ Fetal	death 3		у		23d. Date Mon	of deliver	ry Day Year
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	1 Yes 2 No	4 ☐ Pregnant at time of de ∃ ☐ Unknown	eath 5∟	Other (specify)			IVIOII		Day 16a
9. 0.	r requires that the de been signed by the should be detached	by P	Part II. Other significant conditions contrib	uting to death but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contrib	oute to the	e cause of death?
ds,	quires en sigi vufd be	ted t						1 □ Y	es 2 No 3	3 Prob	ably 4 🗆 Unknown
CO	aw rec as ber 2 shc	Completed						24a. Was a	sy pr	rior to con	sy findings available
Re	sician: The law r certificate has b lirector, page 2 s	S						perfor 1 Yes		eath?	2 🗆 No
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>	ding Physician: h. After this certific funeral director,	은			ER/Outpatien 28b. Time of	t 3 DOA 28c. Injury	4 L Nursing Ho		ence 6 X Other		Living
u C	nding ath. r: Afte ie fune	icate	Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	work	? Yes 2 □ No		- mary coodinoc		
Division of Vital Records,	r Atte ter de irecto	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	8e. Place of Injury - At hor building, etc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (St City or Town	treet and Number	or Rural F	Route Number,
	pital o				1 1 - 11						
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	To the comp		29b. Signature and title of certifler	ionoriori io mio pode el my	interiouge, e	29c, License	number	. 2	29d. Date signed		
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25	و ا		30. Name and address of person who compl		, , , , ,	· ·					200553
	Stat	e ´	Jennifer Schmidt, 31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ıre	ants Lane	, Suite	205, Lec	nardtow	<u>a, MI</u>	20650
	Registra		AUG 0 2 2010	Drews 1	1. 40	wes					
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Baltimore, Maryland 21215-0036

		For		State of	f Marylan	_				and M	lental Hy	giene	201	Ω	2522
		State Registrar	<i>—</i>	141		Cer	tificate	of De	eath			Reg. No.	201	U	2533
Physicia Medic		Decedent's Name	Harr	W. Kil	llgo						2. Date of De		2010 Year		3. Time of Death 10:05 Р м
Examin	er	4a. Facility Name (if note 13300 Do		•	ber)		4b. City, To			of Death Spri	lng		County of Dea		у
Funeral Director		5. Social Security Nur 577-18-94		6. Sex 1 <b>X</b> M 2 □ F	7. Age (In yrs la <b>91</b>	ast birthday) Yrs.	If Under 1 Months		If Under Hours	24 Hrs. Min.	8. Date of Bir Jan . 1	th y, Year) 191	.9 9. B	irthpla ountry	ce (State or Foreign DC
land show dat	tor	Usual Residence of D 10a. State	Decedent 10b. County		10c. Cit	y, Town or Loc	cation							100	d. Inside City Limits
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Marries 3 ☐ Widowed 4		Armed Formed 1 X Yes If Yes, Given Year or Date	2 🗆 No		Yes, specify  Yes 2	_			Hican, etc.)	s	Black, Whi pecify: Af Am	ri	
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permit. P Departm Importa any inju once.		21. Signature of Fune			Met	22	. Name and A	Address	of Facilit	y St	ewart :	Funer	al Hom	ne,	
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Medical Examiner		resulting in death)		Due to (d	or as a consequ	ience of):									
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		29b. Signature and tit	le of certifier	-h- n			29c. Li	icense n	umber 0054.	2/.1			signed (Mon		
5		30. Name and addres	s of person w	ho completed cause	of death (Item	23a) (Type, P	rint)	יע		<b>441</b>		J1	11y 28	, 4	010.
El,		Deidra E	. Wood:	s, MD 5530	) Wisco	nsin A	ve. Su	ite	1400	0 C1	nevy Ch	ase,	Md.	208	15
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Amend Item Registrar	State of M 25 per me	aryland / Depo g907,0970 Cer	rtment of H 1/2010dhb tificate of D	lealth and N De <i>ath</i>	flental Hygi	ene g. No.2 N   N	05000
			Decedent's Name (First, Middle, Landson)					2. Date of Death		3. Time of Death
	Physicia Medio		Shirley A	nn Kidd				Month 7	Day Year	5:30 P M
~ ~	` Examin		4a. Facility Name (if not institution, given			4b. City, Town, or	Location of Death	· · · · · · · · · · · · · · · · · · ·	4c. County of Death	1
-			St. Mary's Nurs			Leonard			St. Mar	y <b>'</b> s
H	Funeral Director		578-46-5319	Sex 7. Ag 1 ☐ M 2 🛣 F	e (În yrs. last birthday)  73  Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) June 22,	Year) Cou	hplace (State or Foreign Intry) District Olumbia
	d iow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Loc	cation				10d. Inside City Limits
	anylar a-fst fied	S								1 Yes 2X No
	or 28	Ö	Maryland St. Mar 10e. Street and Number	ry's	Hollywo	Od 10f. Zip Code		10	Og. Citizen of What Co	
	with t	Funeral Director	0/066 0-1-11 0-	11			636		USA	<b>,</b> .
	eath tems	Ē	24966 Cuckold Cox 11. Marital Status	12. Was Decedent 6		Vas Decedent of His	spanic Origin? (Spe	cify Yes or No-	14. Race - Amer	ican Indian,
36	72 hours after death with the Maryland n "natural", or items 23a or 28a-f show ledical Examiner must be notified at	ğ	1 ☐ Never Married 2 ☐ Married 3 🔣 Widowed 4 ☐ Divorced	If Yes, Give	No	FYes, specify Cubar  ☐ Yes 2 🛣 No		Rican, etc.)	Black, White Specify:	
8	ours atura cal E	etec	15. Decedent's	Year or Dates.	16a Deced	lent's Usual Occupa	tion		Whi	
21215-0036	72 h an "n Medi	Completed	(Specify only highest of Elementary/Seconday (0-12)		(Give I	kind of work done di O NOT use retired)	uring most of worki	ing	I6b. Kind of Business I	ndustry
212	withir giene er th		11	College (1-4 or s	, I	Process	ing		AFL-CIO	_
	filed d oth event	o Be	17. Father's Name (First, Middle, Last	)			18. Mother's Name	e (First, Middle, Ma	aiden Surname)	
Уa	should be file and Mental H 7 is marked o raumatic eve	2	Harry Limerick				Agnes N	lalley		
Maryland	2 shot h and 7 is n traun		19a. Informant's Name/Relationship			,		,	City or Town, State, Zip	,
	and 2 Healt tem 2		Rohert Eugene Kid 20a. Method of Disposition	d, III / S	op 8512 20b. Place of Dispo				VA 22407	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I once.		1X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		cemetery, cren	natory or other place	) August	7,	,	
薑	mit. Partme		21. Signature of Funeral Service Lice		Mt. Olivet		s of Facility Mat		Washington rdiner Funera	
ñ	permi Depar Impor any ir	1	Kenneth Phil	les.	1				Leonardtown,	
			23a. Part 1. Enter the disease, or conshock, or heart failure. List only	nplications that caused one cause on each line	the death. Do not ente	r the mode of dying	, such as cardiac c	or respiratory arres	t,	Approximate Interval Between
	Pnysician/	1	Immediate Cause (Final disease or condition	Tona	menal.	Canhan	kn-			Onset and Death
	Medical Examiner		resulting in death)	Due to (or as	a consequence of):	11 4	1-1-	1		2 41
		er	Sequentially list conditions,	b. Con	consequence of ?	MEan	Mack	wis	elacud EXAMINER	2WDV.
	red nsit	Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	(Va	D - on	ALL SAG	Ohu	1 de	QUALEXAMINER	45
	execu in and ial-tra	Ex	that initiated events resulting in death) Last	Due to (or as	a consequence of):	To face	100	LOBBOVED BY	MEDICAL	T
09	sate be executed physician and the burial-transit	edical		d		<u> </u>	CERTIFICAT	JON AFT	QOCCHOCAL EXAMINER	
	rtifica ling pl e as tl		IF FEMALE:	00-16						
Box 687	ath ce attend for us	ian,	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Fetal death 3 _	Ectopic pregnancy Other (specify)	1		23d. Date of deli Month	very Day Year
m.	requires that the death certific been signed by the attending I should be detached for use as	Physician/M	1  Yes 2  No 9  Unknown	g Unknown	t time of death 3 =	Other (specify)				
P.O.	that the ned by deta	by P	Part II. Other significant conditions	contributing to death b	ut not resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ds,	quires en sig uld be	pe	meumi	nell	r -			1 🗌 Yes	s 2 <b>8</b> No 3 $\square$ Pr	obably 4 🗆 Unknown
COL	aw rec as bee 2 sho	Completed	Paroplea	a ITOZ	Drawy	ESTE M	yelita	24a. Was an autopsy		opsy findings available ompletion of cause of
Re	The larate hapage	Corr		,			1	perform 1 \sum Yes 2	ed? death?	2 🗆 No
tal	cian; sertific setor,	Be	25. Was case referred to medical examiner?  1 💹 Yes 2 📆 No	Hospital:	7-2		ce of Death (Check	only one)		
Ž	Physi this c	٠. ا	1 A Yes 2 7000 27. Manner of Death	1 🗆 Inpati	ent 2 ER/Outpatien		4 Mursing Ho		nce 6 Other (Speci	fy)
o u	ding th. After funer	cate	1 ■ Natural 5 □ Pending 2 □ Accident Investigation	(Month, Day	/, Year) injury	28c. Injury work? M 1 \(\subseteq\)	es 2 □ No	28d. Describe how	/ injury occurred	
isio	Atten	Certificate:	3 Suicide 6 Could not	be 28e. Place of Inju	ury - At home, farm, stre				eet and Number or Run	al Route Number,
Division of Vital Records,	tal or rs afte al Dire		4 - Holmoide determine	building, etc	c. (Specify)			City or Town,	State)	
	To the Hospital or Attending Physician; The law requires that the death certifical within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending is completed filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 2 Medical Exar	niner: On the basis of e	my knowledge, death o xamination and/or invest	igation, in my opinior	n, death occurred at	the time, date and	place, and due to the c	ause(s) and manner stated.
	To the within 2 To the Comple	Σ	only one) 3 ☐ Certifying Nu 29b. Signature and title of certifier	A PLACTIONEL: 10 the	best of my knowledge, d	29c, License			d. Date signed (Month	
			b land	14. hom	DE ALL	ND	0641	9	8-1-17	)
. /	,		30. Name and address of person who	completed cause of d	eath (Item 23a) (Type, P	rint)	- / .		- 10	
للط	<i>U</i> -			ch Road, Ho	ollywood, M	aryland 2	20636			
	Stat Registra		31. Date filed (Monty, Day, Year)  AUG U 4 20	32 Registra	ar's Signature	Kel				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 20°10 М Susan Marie Kauffman August 1620 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospice House of St. Mary's Callaway 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral 8. Date of Birth Days 1 M 2 K F Months Hours Min (Month Day, Year) 05/13/1953 Director Pennsylvania 205-42-4500 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If firen 27 is marked other than "natural", or from any injury or other trailmetic. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2X No. Maryland St. Mary's Valley Lee 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 19547 Hickory Hills Lane 20692 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Florist Flower Shop Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Wilbur Ρ. Blumenshine Dolores Bongart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earl Kauffman/Husband 19547 Hickory Hills Ln., Valley Lee, MD 20692 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arlington National 09/02/2010 Arlington, VA 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Brinsfield, M00052 Jr. 22955 Hollywood Rd., Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on a y line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical as a consequence of): Due to (or Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Ener Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospice examiner: Other: 4 Nursing Home 5 Residence 6 XXOther (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA House 27. Manner of Death

The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760 ed by the a detached f signed t peen has certificate To the Hospital or Attending Physician: this filled in by the funeral . After t 24 hours a

28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural injury 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month) Day\_

completed

within 2

31. Date filed (Month, Day, Year) State Registrar

30. Name and address

Jenni**ge**r

40900 Merchants Lan., Leonardtown, MD 20650 32. Registrar's Signature

of person who completed cause of death (Item 23a) (Type, Print)

D.O.

Schmidt,

AHG 06

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Albert Thomas Kapusinski 30 M 2016 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death County of Death Peninsula Regional Medical Center licomico Salisb Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Oct. 16, 1937 Hours New York 089-30-8229 72 Director Usual Residence of Decedent or items 23a or 28a-f show nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland arment of Health and Mertal Hygiene. ordant: If tiem 27 is marked other than "natural", or items 23a or 28a-f shooriant: If tiem 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21801 TISA 6410 Riawakin Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U 11 Marital Status 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give 1958-Black White etc. Baltimore, Maryland 21215-0036 ģ 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: 1963 Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Professor Education Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Anne Olbreys Casimir Kapusinski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 7 Longview Road, Cedar Grove, NJ 07009 Frank Kapusinski/Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 X Removal from State 8/4/2010 Whitehall, NY 4 Donation 5 Other (Specify Our Lady Of Angels 21. Signature of uneral Service License 22. Name and Address of Facility Zeller Funeral Home, P. O. Box 207 106 Main Street, East New Market, MD 21631 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ MULTIPLE SETEM ORCAN FAMILYE disease or condition Medical resulting in death) Examiner ZVZEVLS O'ZWARY ARTERY BYPASS AND MITZAL quantially fist conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine per ME Offi Due to (or as a consequence of): 45425 Due to (or as a consequence of): つくりゃん and -trans resulting in death) Last burialattending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia IE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery OK as is Division of Vital Records, P.O. Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CONCESTIVE HEART FAMILE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an RENAL WESTERCIEN CHRanc autopsy performed? page death? 1 Yes 2 No 2 No Yes 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one) Hospital 2 340 Other: 잍 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical Provision: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Cutifying yourse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signatu and title of c 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

30. Name and addre

ames

Carroll St.

s of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25335 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 27, 2010 Zenas 3:07 Рм Ezra Layman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 18820 Cross Country Lane Gaithersburg Montgomery Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🕱 M 2 □ F Days Hours 225-28-0592 87  $J_{\mathbf{u}}^{(Month, Day, 1923)}$ Virginia Director Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Gaithersburg Montgomery 1 🗆 Yes 2 🛛 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18820 Cross Country Lane 20879 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. White Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. sant: If item 27 is marked other than 'ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Katie Y. Horst John Calvin Layman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 18820 Cross Country Lane Gaithersburg, MD 20879 Janice Dillon (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State Aug 10 1 X Burial 2 Cremation 3 X Removal from State Warwick River of other place) New Port News, VA 4 Donation 5 Other (Specify) Mennonite Cemetery Signature of Funeral Service Vicense 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Rary 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cerebral Vascular Accident disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami law requires that the death certificate be executed physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ ed by the atten detached for u in the past 12 months?
1 ☐ Yes 2 ☐ No Month 9 Unknown 9 Unknown P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 🗆 Yes 2 🗆 No 3 🗆 Probably 4 😾 Unknown should k been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? page or Attending Physician: The After this certificate 1 ☐ Yes 2 ☐ No 2 💢 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \( \triangle \text{Nursing Home} \) 5 \( \triangle \text{Residence} \) 6 \( \text{X} \) Other (Specify) Residence 1 Yes 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred **X**Natural 5 Pending Division 2 No 1 Yes Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title 29c. License number 29d. Date signed (Month. Day. Year) D39793 July 28, 2010

State Registrar

DHMH 17 Rev 7/2009

18111 Prince Philip Dr. #207

Olney, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Dr. Christopher J. Mays M.D.

JUL 29 2010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25336 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 25, 2010 Shirley B. Linsao 12:00 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Howard Ellicott City Ellicott City Nursing and Rehab Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 I Year 1938 Hours July 11 Maryland Director 217-34-8022 72 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2X No Maryland Howard Ellicott City 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3449 Harrington Drive 21042 United States items death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. . or ģ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: "natural" Completed 3 Widowed 4X Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 1 amy injury or other traumatic event, the Meaonce. Morningside Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Assisted Living Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Elmer Balderson Laura E. Avalon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William R. Linsao/son 3449 Harrington Drive Ellicott City, Maryland 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State Final Journey Crematory 7/29/2010 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, Maryland 21. Sign to e of Funeral Service Licens Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 M00957 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between ances Immediate Cause (Final Onset and Death Physician/ nta disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of that the death certificate be executed the burial-transit and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death 5 Other (specify) ed by the a Unknown P.O. | signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 2 [ ER/Outpatient 3 DOA 1 Inpatient 2 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or investigation in my policies. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 □ To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 130641 1 aw Back River neck Road baltomer Maryle 30. Name and address of person who completed cause of death (Item 23a) (Type, Print

Registrar DHMH 17 Rev 7/2009

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Patrick Michael McGovern State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar				Certific	cate of	Death					Reg. N	0.			
Physicia Medical Exami	ın/	1. Decedent's Name (First, Midd Patrick Michael		Govern							i i	Date of De Month August 6	Day		r	3. Time of 0225	
		4a. Facility Name (if not instituted 4512 Valley Forge	n, give	street and n	umber)		41	City, To		Location	of Death	<u> </u>	ľ	4c. County o			
Funeral Director		5. Social Security Number 212–27–1811	6. Sex	M 2 F	7. Age (I	n yrs. last bir	rthday) Yrs.	If Under Months		_		8. Date of	,	M/DD/YYYY	Foreign		ate or
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Maryland 28a-f show any d at once.	5	MD 10a. State 10b. County	Mor	ntqomer		c. City, Town	or Location										e City Limits s 2 🕱 No
the Maryl a or 28a-1	Director	10e. Street and Number 4512 Valley For	ge Di	rive				10f. Zip C	ode 2085	53				itizen of Wh JSA	at Coun	ry?	
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland men tof Heath and Mental Hygiene.  tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 X Never Married 2 M. 3 Widowed 4 Div	arried	12. Was Dec Armed F 1 Yes f Yes, Give Yes or Dates:	orces?		If Yes		Cuban,	Mexican	, Puerto Ri	cify Yes or I ican, etc.)	No-	14. Race White Specify:		an Indian, te	Black,
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21215-0036 muld be filed within 7 Mental Hygiene. marked other than c event, the Medica	mo Mo	17. Father's Name (First, Middle,	Last)										, Maide	n Surname)			
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e, MD 21215-003 I and 2 should be filed withi Health and Mental Hygiene, item 27 is marked other th r traumartic event, the Med	ř	John H. McGovern,												City or Town 20853	ı, State,	Zip Code)	
Baltimore, oemit. Pages I and Department of Heal Important: If iten njury or other tra		20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other Sp		Removal fr	om State	20b. Place cremai Metro	of Dispositi tory or othe polita				Aug. 20:		- 1	Location - Lexandi	-		<del>)</del>
Baltimor permit. Pages Department of Important: If	1	21. Signature of Funeral Service	License	0				ne and Ad				ral Hor	ne In	c. oring ,	4D 20	001	
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Examiner		Immediate Cause (Final disease or condition resulting in death)	_	cardio le to (or as a			disea	se '							_	D	Death
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Division ital or Atte urs after der ral Directo	Certification:	3 Suicide 6 Could	igation not be nined	28e. Place (Specify)	e of Injury	- At home, fa	arm, street,	factory, of	fice bu	ilding, etc	28	or Town,		and Number	or Rura	I Route N	umber, City
Division of Vital Records, P.C. To the Hospital or Attending Physician: The law requires that within 24 hours after death. To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be deta	ल	29a. Ĉertifier 1 Certifying Ph (Check only one) 2 Medical Exar	niner: 0		of examina												
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15/64		30. Name and address of person	M who cor	npleted caus	e of death	(Item 23a)			D.C.M	1.E.	000	ıτ	Au	gust 6, 20	010		
- 1	-	Theodore M. King, Jr.,				cal Exam	iner 1	11 Penr	Stre	et, Bal	timore, l	MD 2120	)1				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2 Date of Death I. Decedent's Name (First, Middle, Last) 21ay 2010a 2:25 PM Physician/ JULY MULLER ROYSTON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S CHEVERLY PRINCE GEORGE'S HOSPITAL If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex 1 **X** M 2 □ F Funeral Days Hours DEC. 30 1927 GUYANA 82 118-46-7609 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f shown notified at filed within 72 hours after death with the Maryland Director 1 ¥ Yes 2 □ No UPPER MARLBORO PRINCE GEORGE'S MD 10f, Zip Code 10a. Citizen of What Country? 10e. Street and Numbe "natural", or items 23a o edical Examiner must be Funeral USA 20774 10204 CASADE LANE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Never Married 2 X Married ð Baltimore, Maryland 21215-0036 Speci BLACK 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **GOVERNMENT** WELDER 12TH permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ ALBERTA JONES FITZALBERT MULLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CYNTHIA SEALEY MULLER/WIFE 10204 CASADE LANE UPPER MARLBORO, MARYLAND 20774 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date ☐ Burial 2 X Cremation 3 ☐ Removal from State RIVERDALE CREMATORY 7/24/2010 RIVERDALE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) ral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ ME ermina disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of). any, leading to immediate cause. Enter Underlying Cause (Disease or linjury the attending physician and hed for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Dav Year Pregnant at time of death 2 🗌 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2 s autopsy 1 ☐ Yes 2 😾 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 X No <u>۾</u> 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury 28b. Time of 28c 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accident 5 Pending work 1 Tes 2 No Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

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6128 LANDOVER ROAD CHEVERLY, MARYLAND 20785 MARGARET AKPAN M.D. 31. Date filed (Month, Day, Year, 32. Registrar's Signature JUL 2 9 2010 ack

30. Name and address of person who competed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certific

29c. License number

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		for State Registrar	State	e of Ma	aryland		rtment of I tificate of I		and M	lental Hy	gier/ Reg. 1	2010	25	339
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Examin	er	4a. Facility Name (if not institution 3025 Sunset L		number)			4b. City, Town, o		of Death			4c. County of Dea <b>Prince</b> G		0
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the Ho nin 24 the Fu nplete		only one) 3 Certifying										ce, and due to the e(s) and manner as		anner stated
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8	ŀ	30. Name and address of person v					nt)					uly 27,		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25340 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ AGNES MILLER 2010 11: 45p<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES FT. WASHINGTON FT. WASHINGTON HEALTH & REHAB If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral XENTUCKY Hours (Month, Day, Year /28/1923 Months Davs Min. 87 ESCO. Director 235-28-6107 Usual Residence of Decedent ? is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director FORT WASHINGTON 1 Yes 2 ☐ No MD PRINCE GEORGES 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral UNITED STATES 20744 1605 BRAKEFIELD CT. within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ₩ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 K No Specify. Hygiene. Specify: BLACK 3 🙀 Widowed 4 🗆 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) SCHOOL SYSTEMS CAFETERIA WORKER 9th grade and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ EDWINA CARTER ROBERT HENRY MAJORS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 1605 BRAKEFIELD CT. FT. WASHINGTON, MD 20744 THERESA M. WILLIAMS/ daughter Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 de Burial 2 Cremation 3 Removal from State 7/31/2010 SUITLAND, MARYLAND LINCOLN CEMETERY 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility JOHN T. RHINES FUNERAL HOME, LLC 3005 12th ST. NE WASHINGTON, DC 20017 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death **6weeks** Immediate Cause (Final Physician/ COLON CANCER disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 6weeks ANEMIA Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): 6weeks that the death certificate be executed LOWER G - I BLEEDING that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Live Birth 2 L Fetal deat Pregnant at time of death in the past 12 months? Day Month Year g Unknown 9 Unknown P.O. signed I Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has the completed filled in by the funeral director, page 2 s autopsy performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Be examiner's Other: 4 R Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2 No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury 1 Yes 2 No Accident M Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatura and title of 29c. License number 29d. Date signed (Month, Day, Year) D 24535 JULY 27, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LAXMI BERWA M.D. 7700 BRANCH AVE. CLINTON, MD 20735 SUITE C101

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JUL 2 9 2010

32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiens 25341 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 7/26/2010 Viola F. Miazga A M 7:55 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 □ M 2 🕱 F Months Director 577-30-8627 85 1/21/1925 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 28a-f show 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f sl 1 X Yes 2 □ No MD Prince George's University Park 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 4211 Tuckerman Street 20782 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married or Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: þ Specify: 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ed other than "re Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be file Health and Mental H tem 27 is marked oth James Feher ပ Julia Kolumbia 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janina Stangebye / Daughter ortant; If item 27 injury or other t 16 Riverside Drive, Roswell, NM 88201 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 Department or Important: If any injury or 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemet: 9/20/2010 Arlington, Virginia 21. Signature of Furieral Service: Licensee 22. Name and Address of Facility 4739 Baltimore Avenue dellen men Gasch's Funeral Home, PA Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE Physician MYOCARDIAL INFARCTION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner FAILURE CONGESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed and burial-trar resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ Yo 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) the 9 Unknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPER TON SION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an perform certificate 1 □ Yes 2 □ No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 | Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide the Hospital 1 ECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of cortine 29c. License number 29d. Date signed (Month, Day, Year) JULY 27, 2010 D 40324 1 30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print) PARK MARYLAND TAKOMA 7600 CARRULL AVENUE JODRIE, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 3 0 2010 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene per MD, RG FCHD / 2/110

1 - State Amended #23b per MD, RG FCHD / 2/110

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ harles youth y 2 010 Merrill 2052 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gaithersburg Montgomery Shady Grove Adventist Hospital . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🙀 M 2 🗆 F Days 222-50-7072 Months Hours Min. (Month, Day, Year) une II, 1959 Nebraska 51 Yrs Director June Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 ☐ No Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20874 USA 20233 Laurel Hill Way Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: white If Yes, Give 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Pharmaceutical Accounts receivable Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Thomas F. Merrill Mary J. Mong injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Anna Jenny Merrill - wife 20874 20233 Laurel Hill Way, Germantown, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specific) cemetery, crematory or other place) Donation 5 Other (Specify) Glade Cemetery 7-24-2010 Walkersville, Maryland nature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Arrest Physician/ rdiac minutes disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner <u> Atherosclerotic Cardiovascular</u> Disease Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): attending physician for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s prior to comp death? has performed Yes 2 within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page 2 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 1 🗌 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 🗌 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 18 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 medical Ctr Dr Rockville, MD 20850 Nancy OSh 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? [] | [] State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month LILLIAN C. MOORE 0147 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death aston Hospita Memoria a) D07 If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) PT • 17,1930 1 🗌 M 2 🕱 F Hours Min. MARY LAND Director 214-32-0826 79 SEPT. Usual Residence of Decedent show 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10d. Inside City Limits Director QUEEN ANNE'S MD CENTREVILLE 1 X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21617 USA 212 OAK STREET 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. Completed by 2 X No 1 Never Married 2 X Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced WHITE Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) be filed within College (1-4 or 5+) OWN HOME 11 -0-HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ LILLIAN LARRIMORE WILLIAM H. COMEGYS, SR. t. Page 1 and 2 should b tment of Health and Mer rtant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 212 OAK STREET, CENTREVILLE, MD 21617 REV. CLARENCE P. MOORE/HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
CHESAPEAKE CREMATION
CENTER Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 7-28-2010 STEVENSVILLE, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facilit FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of Exami Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician should be detached for use as the burial Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Month Day Pregnant at time of death Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has I autopsy performed Yes 2 , page 2: 25. Was case referred to medical examiner? completed filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No ၉ 1 🗌 Yes 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? Natural 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A 2 No Investigation Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) MO 31. Date filed (Month, Day, Year) Registrar's Signature State JUL 28 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene FoAMEND#22 per FH State 7/28/2010 AACO HEALTH CMH Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 07 2 Day 2010 FRANCIS G. MARTIN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death ARUNDEL ANAMPOLIS ANNE MEDICAL ALUNDEL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months 1 🔀 M 2 🗆 F Davs Hours Janth, 2977 Year 1954 Mary land 213-64-4404 56 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d, Inside City Limits with the Maryland Director Maryland Anne Arundel Annapolis 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 29 West Washington St. Apt 304 21401 USA death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1X Never Married 2 Married Baltimore, Maryland 21215-0036 nours after 1 Yes 2 No Specify: If Yes, Give Specify: "natural", 3 Widowed 4 Divorced **Black** Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Annapolis life. DO NOT use retired) Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 11th 0 Construction Construction Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Martin Christine Bias 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ophelia S. Wilson(Friend) 990 Ponds Wood Rd. Huntington, Md. 20639 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/2/10 Baltimore, Md. Metro Crematory 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 mc0483 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line METASTATIC LUNG CANCER Immediate Cause (Final Physician, disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) -transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): physician s the burial Physician/Medical requires that the death certificate be Box 68760 as attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death signed by the aid be detached f P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPOGLYCEMIA Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed Yes 2 page death? in 24 hours after death.

Je Funeral Director: After this certificate hapleted filled in by the funeral director, page 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be 1 ☐ Yes 2 No Other: <u>ام</u> 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: or Attending Natural 5  $\square$  Pending work 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical 29a. Certifier \*\*X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F 29b. Signature and title of certifi-29d. Date signed (Month, Day, Year) 25 D66753 NO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

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32. Registrar's Signature

MD

M. Capstac

Timothy

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland Peges 1 and 2 should be filed within 72 hours after death with the Maryland Heath and Mental Hygiene. Thit: If team 27 is marked other than "natural", or items 23a or 28a-f show my or other traumatic event, Ital Marical Examination in the Lordinal Programment of		20a. Method of Dis		Removal from State	20b. Pla	ace of Dispo metery, crer	sition (Name of natory or other pla	ce)	July			ocation - City o		
Pag Iment		4 ☐ Donation	5 ☐Other (Speci	fy)	Met		ematory,		201	0		timore,		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan D-partment of Health and Mental Hygiene. In portant: If then Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Marical Examination in the Landelle Andrews.		21. Signature of Fu	ineral Service Lice	nsee		Ë	Name and Address Name and Address	ss of Fac SO	ns, P.	A. Sev	erna	Park I	uneral	. Home
20780	r /	///				4	95 Ritch	ie H	wy,	Sev	erna	Park,	MD 211	46
		shock, or ma	irt failure. List only	one cause on each li	d the death. ne.	Do not ent	1		)	respiratory a	irrest,		Approxim Interval E Onset an	Between
Physician /Medical		Immediate Cause disease or condition resulting in death)	(Final on	a adv			dem	en	77a				yea	us
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_ × × ± =	일	1 ☐ Yes 2 □	No	Hospital: 1 ☐ Inpatio		R/Outpatier	nt 3 DCA Oth	4 🗀	Nursing Hom	e 5 🗆 Res	dence	6 ☐ Other (Sp	ecify)	
ding Ph h. After th funeral		27. Mann of Deat 1 Valural	5 Pending	28a. Date of Inju (Month, Da	ıry ıy, Year)	28b. Time o Injury	Wor			d. Describe	how inju	ry occurred		
ttend death death ttor:	icat	2 ☐ Accident 3 ☐ Suicide	investigatio 6  ☐ Could not b		un. At hon	no form str	M 1 C	Yes 2		of Location	Ctrant	nd Number or I	Jum I Causta M	umbar
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To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	(Check only one)	2 ☐ Medical Exa	miner: On the basis of and manner st		on and/or in	vestigation, in my	opinion, o	death occurre	d at the time,	date an	d place, and de	e to the cause	e(s)
Vithin vithin comp	M	29b. Signature and	title of certifier			4.4.5	29c. Licens	se numbe	er		29d. Da	ate signed (Mo	nth, Day, Year,	)
		/	/(/	N	/	VUD	Print)	50	105		7	- 7	1 - 20	010
		30. Name and add	ess of person who	completed cause of c	leath (Item	23a) (Type,	Print)	11		11/1	-	11	1111	2/1/10
વંછ		31. Date filed (Mon	th Day Year	Jincol 37. Registr	ar's Signatu	II Ve	Terans	116	141	NILL	WS	rice ,	vii	1.00
Sta Registra	_	Jl	JL 2 8 201	0	, A	he	del.							
	1			person	μ.	gar								

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . 201<u>0</u> July 27, **Physician** 2:30 p Van Nguyen /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver Spring Montgomery 619 Northampton Drive If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Social Security Number **Funeral** Days Months Hours MIM 2 F Vietnam 17, 1947 63 July Director 212-43-6655 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show at 1 ☐ Yes 2 No r than "natural", or items 23a or 28a-f st the Medical Examiner must be notified Directo Silver Spring Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20903 USA 619 Northampton Drive Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after of Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify.Asian 1 ☐ Yes 2 XNo ò 3 □ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Clothing Imprinting Printer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be He Thi Le Tai Van Nguyen 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 619 Northampton Drive, Silver Spring, MD 20903 Tuan Nguyen/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State July 30 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2010 Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc 500 University Blvd. W., Silver Spr Spring, MD 20901 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List sally one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 5 years a Hepatocellular Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed burial-transi Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9☐Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No cate has b autopsy performed? res 2 1 No certificate 1∐ Yes To the Hospital or Autorities within 24 hours after death. To the Funeral Director: After this certifies 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 XNo 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Injury 12-XNatural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

State Registrar

Naomi Horeb. 31. Date filed (Month, Day, Year)

29

29b. Signature and title of certifier

(Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Greene 32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Baltimore 212

29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

				8.PerFHPGC8-9			partment of I ertificate of I				Reg. N	7	0	25347
Physicia Medic		1. Decedent's Name Joseph 0	la-Ifa	,		_				2, Date of De Month July 2	D	2010	Year	3. Time of Death 12:17 P M
Examin	ner			give street and number) Hospital (		r	4b. City, Town, o	_	n of Death			c. County o		eorge's
Funeral		5. Social Security No		6. Sex 7. A		ast birthday)	If Under 1 Year Months Days	If Und	er 24 Hrs.	8. Date of Bir	th		g. Birtl	hplace (State or Foreign
Director		578-19-7 Usual Residence of		1 🖾 M 2 🗆 F	77	Yrs.	World Days	Hours	IVIIII.	Apr 23	, 19	933	N	ntry) Nigeria
land show dat	tor	10a. State	10b. County		10c. Cit	y, Town or L	ocation							10d. Inside City Limits
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with th	Funeral I	5999 Eme		reet			10f. Zip Code	20710	)		10g. C	itizen of W USA		untry?
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1 and of Heal item		20a. Method of Disp	oosition		20b. F	Place of Disp	3 South S osition (Name of ematory or other place			Date				0633 Town, State
per it. Page 1 and 2 should be filed within 72 hours after death with the Maryland Des artment of Heath and Mental Hygiene. Des artment of Heath and Mental Hygiene. Des artment of the maryland the man and mental Hygiene. The man are do ther than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			☐ Cremation 3 5 ☐ Other (Sp.	B ☐ Removal from State ecify)			L Cemeter:		8/7/	2010				ryland
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ath cel attend for use	cian/	23b. Was decedent in the past 12 r	months?	23c. If yes, outcome 1  Live Birth 4  Pregnant	2 🗌 Feta	death 3	Ectopic pregnand	су			(1)	23d. Date Mon		very Day Year
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obstance of the families of the families of the families of the death.  Uneral Director: After this certificate has lad filled in by the funeral director, page 2 s	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could no determine	28e. Place of In	jury - At ho tc. (Specify,		reet, factory, office			28f. Location (S City or Tow			or Rura	al Route Number,
To ure nospiral or Authoring Prysician: The lawithin 24 hours after death.  To the Funeral Director: After this certificate he completed filled in by the funeral director, page.	Medical	29a. Certifier 1 (Check 2			examinatior	and/or inve	stigation, in my opinio	on, death	occurred a	t the time, date a	and place	e, and due t	the ca	ause(s) and manner stated.
vithin 2 Forthe I	M		☐ Certifying N	urse Practioner: To the				e time, da		e, and due to the	e cause		ner as s	stated.
1			4	1 Stell	m	N	Da	34	10	39	7	127	1/2	010
20		30. Name and addre	ess of person wh	o completed cause of	death (Item	23a) (Type,	Print) A Hana	ve -	-Parc	4,1201	, ,	(0000	inla a	df MD 20710
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** MON, GOL 8. Date of Birth 9. Birthplace (State Foreian **Funeral** 1 □ M 2 🗓 F Months Hours (Manth 04) 1925 **Director** 341-18-9174 84 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10000 Brunswick Avenue, 20910 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. Specify: Completed 3 X Widowed 4 Divorced Caucasian Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Fred Mortensen Kathrun Mae Watterman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian Penoyer - Son 9710 Lawndale Avenue, Silver Spring, Maryland 20901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cedar Park Cemetery | 07/31/2010 | Chicago, Illinois 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to for as a consequence of: if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events or Attending Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 
Yes 2 No for Yea Pregnant at time of death should be detached Unknown g Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has t completed filled in by the funeral director, page 2 s autopsy 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Hospital Other: 2 1 🗌 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Dea h 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital within 24 hours a To the Funeral C Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifie Go physing Nurse Practioners to this best of my knowledge, death origined at the time, date and place, and due to the cause (s) and marries as state. 29b. Signature and title of certifier 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 91. Date filed (Month, Day, War)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 7 0 1 0 Certificate of Death Registrar AMEND#8per INF, 8-2-10, BMW, McCo 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1645 PM PATEL YANTIBHAI Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** OF MARYLAND BALTIMORE 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of 12-11-1940 . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Days Hours Min INDIA Director 209-68-3434 Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location filed within 72 hours after death with the Maryland items 23a or 28a-f sho her must be notified at 10d. Inside City Limits Director 1 X Yes 2 No MD. HOWARD **JESSUP** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7931 FAWN RUN 20794 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Was Deceden \_\_\_\_\_ Armed Forces? 1 ☐ Yes 2 🔀 No Black, White, etc. 9 þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: ASIAN INDIAN "natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) CASHIER RETAIL STORE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked ot any injury or other traumatic even ၉ PATEL CHANCHALBEN PATEL DESAIBHAI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MITESHKUMAR PATEL/SON FAWN RUN, JESSUP, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-29-2010 CHAMBERS CREMATORY RIVERDALE, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. M00091 CLEVELAND RIVERDALE. 5801 AVE.. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final e and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner te has Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Cause (Disease or linjury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed Okoho and burial-trar attending physician Division of Vital Records, P.O. Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months? Month Dav Year Pregnant at time of death 2 No signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy 2 2 No \_\_ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 🗷 No Other: 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) . Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending | After work? iniury Vatural 5 Pending safter death.

I Director: Affine by the full Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide pleted filled in by determined City or Town, State) within 24 hours a Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cartifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signat certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

of person who completed cause of death (Item 23a) (Type, Print)

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		Registrar  1. Decedent's Name (First	, Middle, Las	st)		06/	tineate or	Dodan	2. Date of De	eath		3. Time of Death
Physicia Medic		LESLIE		RU	FFIN				JULY	24 <sup>Day</sup>	2010 <sup>Year</sup>	9:30 P M
Examin		4a. Facility Name (if not in: 6701 ALLI			ber)		4b. City, Town, o	or Location of Deat	h		County of Death	
Funeral Director		5. Social Security Number 579-64-6986	1	ex [ <b>X</b> M 2 □ F	7. Age (In yrs.	. last birthday) Yrs.	If Under 1 Year Months Days			rth 8 194	9. Birti WAST	hplace (State or Foreign TINGTON, DC
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a or 2		10e. Street and Number					10f. Zip Code			10g. Citiz	en of What Co	untry?
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	≧	11. Marital Status  1  Never Married 2  3  Widowed 4  C		12. Was Dece Armed For 1 X Yes If Yes, Giv Year or Da	ces? 2 \(\text{Na}\) Na\(\text{A}\) I	REORGE '	Was Decedent of F f Yes, specify Cub	Hispanic Origin? (S) ean, Mexican, Puert o Specify:	pecity Yes or No- o Rican, etc.)		4. Race - Amer Black, White pecify: BI	
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To the within		29b. Signature and title of	certifier	en or			29c. Licens D47	se number		29d. Date	signed (Month	Day, Year)
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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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, , ,		29b. Signature and title of certifier	$\sim$			29c	License	number			29d. D	ate signed	(Month, E	Day, Year)
5		30. Name and address of person v		e of death (Iter	m 23a) (Type, Pr	rint)	0	240	7 3	)	n.		7	n_
A. S.		31. Date filed (Month, Day, Year)	nald 7	96'3 egistrar's Signa	ature SUCT	ette	SK	011	Til	iton.	11/	C	101	30
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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 23<sup>Day</sup> July GRACE RIGGS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 22041185 Montgomery Shady Grove Hospital Rockville 5. Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 - M 2 1 F Months Days Hours Min. Augnth, Bey, Year 925 136-20-4510 84 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland notified at Director 2016 MD Rockville Montgomery 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Examiner must be 23a Funeral 20850 U.S.A. 9701 Veirs Drive items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces?
1 ☐ Yes 2XXNo といい ō 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XXo Specify: Specify: White "natural", 3 KWidowed 4 □ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) years Teacher Education Rice Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Edward Foster Sadie Lanning 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Riggs Tyler Brooks Dr. Williamsburg, Va 23185 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State RACE cemetery, crematory or other place, 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Quantico Nat. Cem. July 30, 10 Quantico, VA . Signature of Funeral Service Liqu The Hysong Collipany 2222 Wisconsin Ave, NW Washington, DC 20007 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph sician/ ARDIAC ARRHYTHMIA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ENTRICULAR TACHYCARDIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) and -transit that the death certificate be executed DASTROINTESTINAL BLEEDING that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be de by Hospital or Attending Physician: The law requires Completed 24a. Was an autopsy performed? Yes 2 XNo certificate 25. Was case referred to medical æ director 26. Place of Death (Check only one) examiner? Hospital: 2 X No Other: ပ္ 1 Xinpatient 2 ER/Outpatient 3 DOA s after death.

I Director: After this d in by the funeral d 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 1 X Natural 5 Pending 1 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours af To the Funeral Di completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 10

Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) D0064478 24 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 MEDICAL CENTER DRIVE ROCKVILLE MARYLAND MD 32 Registrar's Signature GE EL PLA **ORIGINAL** 

2010

Black, White, etc.

22:04

N.J.

10d. Inside City Limits

Interval Between Onset and Death

XX Yes 2 No

9. Birthplace (State or Foreign

State

FISEHATSION

31. Date filed (Month, Day, Year)

MEHARI

Q 211

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 25353 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 9:50 PM Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death Examiner 4c. County of Death timore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Sex 1 M 2 □ F **Funeral** Hours Min. Feb. 7, 1947 Country) Director 166-36-3422 63 Yrs. Usual Residence of Decedent fshow 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director PA 1 ☐ Yes 2X No Montgomery Gilbertsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2518 Jane Lane 19525 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 🖾 Yes 2 🗆 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married à Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural" 3 Divorced 4 Divorced Completed White Year or Dates. Vietnam other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Technician 12 Telecommunications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Herman Rennard Alice Stanton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Rennard/Wife 2518 Jane Lane, Gilbertsville, PA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of I Important: If ite any injury or ot once. 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) Falkner Swamp Cemetery 8/3/2010 21. Signature of Funeral Service 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 111 S. Queen St., Rising Sun, MD art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Juse (Final disease or condition resulting in death) Priysician/ Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) a 0 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown to the Funeral Director. After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No ည 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nnpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Contifying Nurse Practionar To the basis of my line along to eath occurred at the time, date and place, and due to the cause(s) and manner stated

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State

(Check

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Prigt)

CAROLYN SENGERMD 10No Date filed (Month) Day, Year) egistrar Signature JUL 3 0 2010

29c. License number 1083866834

GREENE Street Baltimore MD 2201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# 2perpHYS, # I8perFH, G906, 8/30/2010, wS

State of Maryland / Department of Health and Mental Hygiene 25354 State Registrar Certificate of Death 2. Date of Death
Month
T<sub>11</sub>Ty Decedent's Name (First, Middle, Last) Day 20<u>10</u> Physician/ 2:30 PM Reichart Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's 30435 Iroquois Lane Charlotte Hall 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday Funeral Days Hours Min. 1 □ M 2 🗓 F August 30, 1922 87 Pennsylvania Director 204-16-4232 Usual Residence of Decedent 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any pines. 10a. State 10b. County 10d. Inside City Limits Director 1 Yes 2 X No St. Mary's Maryland Charlotte Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20622 30435 Iroquois Lane U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 ☐ Never Married 2 🔀 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify White Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Owner/Operator Retail Gift Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Thomas Rottman Sophia Rottman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30435 Iroquois Lane Charlotte Hall, MD 20622 Marie Palmquist/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 8/2/2010 1 Burial 2 X Cremation 3 Removal from State Charlotte Hall, MD 4 ☐ Ponation 5 ☐ Other (Specify) Brinsfield-Echols Crematory 21. Signatur of Funeral Service Licensee M00817 Name and Address of Facility, Brinsfield-Echols Funeral Home, P.A. P.O. Box 128 Charlotte Hall, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 1 Yr Immediate Cause (Final disease or condition Physician/ Congestive Heart Failure Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events physician and the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?

1 Yes 2 No ate has been signed by the attep page 2 should be detached for a Month Day Year ☐ Pregnant at time of death ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy perform death? 2 No 1 🗌 Yes Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 💢 No မှ 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 \( \sum \) Yes 2 \( \sum \) No 1 X Natural injury 5 Pending Accident Suicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) 24 hours Medical 🔟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one 29b. Signatur 29c, License number 29d. Date signed (Month, Day, Year) D28281 08/02/2010

DHMH 17 Rev 7/2009

State Registrar

10 pme

Nelson Benjers, MD 9131 Piscataway Road, Clinton, MD 20735

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Robert Wallace Scott  $\mathbf{J_{u}^{Month}}$  28, 2010 11:30 Am Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Casey House Montgomery Rockville Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 8 Date of Birth Funerai Days Hours Min 1 XM 2 🗆 F 352-26-3646 0572871932 Il Thois **Director** 78 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Bethesda MD Montgomery 1 X Yes 2 No 10f. Zip Code 20814 10e. Street and Number 10g. Citizen of What Country? 4835 Cordell Avenue #1307 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No1952—
If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 White 1 Yes 2 XNo Specify: Specify: 3 ₺ Widowed 4 □ Divorced 1954 Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Decorating Contractor Elementary/Seconday (0-12) College (1-4 or 5+) Painter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles C. Scott ပ Helen Millar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15630 Oakview Ln. South Beloit Illinois 61080 15630 Oakview Ln. South Beloit Douglas P. Scott / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Falls Church, VA 7/30/2010 National Crematory 4 Donation 5 Other (Specify) Signature of Function Service Licens 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Intracerebral Hemmorrhage Ph\_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or imjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Hospital Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 27. Manner of Death 28c. Injury at work?
1 Yes 2 No 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury XNatural 5 Pendina Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Medical 29a. Certifier 🚨 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20+1 7/28/2010 D37142 person who completed cause of death (Item 23a) (Type, Print) Coleman MD 1355 Piccard Dr. Rockville, MD 20852 31. Date filed (Month, Day, Year) State

Registrar

9 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Donna Schroeder July Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Carroll Longview Nursing Center Manchester 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Yes Sept. 10, Months Days Hours Min 68 Director 189-32-4584 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location notified at Director MD Frederick Mt. Airv 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 21771 705 North Warfield Drive United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. δ 1 Never Married 2 Married Maryland 21215-0036 3 Divorced 1 ☐ Yes 2 X No Specify. Specify: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Administrative Assistant Government other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked or မ Louis Drotos Margaret Radachy other traumatic and 2 should b Health and Mer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) De artment of Health ar Important: If item 27 is any injury or other trau Debra L. Schroeder/Daughter 705 North Warfield Drive, Mt. Airy, MD 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory 20a. Method of Disposition 20c. Location - City or Town, State Page 1 1 Burial 2 X Cremation 3 Removal from State July 28 2010 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
DeVol Funeral Home, IRACU 10 East Deer Park Drive, nuck M01117 Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami death certificate be executed ourial-transit and resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death detached 9 Unknown 9 Unknown that the by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by pe Records, Completed 24a. Was an has autopsy performed? Yes 2 X No page certificate Division of Vital funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 X No Other: 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: the Hospital or Attending 1 🕅 Natural 5 Pending injury 24 hours after death. Funeral Director: A 1 Yes 2 No Accident Investigation the Suicide 3 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide upleted filled in by determined City or Town, State) Medical 29a. Certifier (Check To the 1 within 2 To the 1 only one) 29b. Signature 29c. License number

23d. Date of delivery Year Dav 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 Yes 4 X Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, 1 🛴 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. address of person who completed cause of death (Item 23a) (Type, Print) mo 31. Date filed (Month, Day, State Registrar **ORIGINAL** 

25356

3. Time of Death

2:35

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 Tes 2 X No

2010

Black, White, etc.

White

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 27-51 Day 010 **Ь:55** p м Marvin Martin Scroggins-Sr Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Prince Georges Clinton Social Security Number 8. Date of Birth
(Month, Day, Year) 6. Sex 1 XM 2 □ F 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Hours Director 78 474-28-3132 Usual Residence of Decedent or 28a-f show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director MD Prince Goerges Camp Springs 1XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral items 23a 6207 Middleton In-20748 AZU 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Specify: **Black** Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) and Mental Hygiene. Elementary/Seconday (0-12) Post Office Manager U.S. Postal Service other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Scroggins Geraldine White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh ment of Health a tant: If item 27 is Maxine Scroggins / wife 6207 Middleton Ln., Camp Springs, MD 20748 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Penation 5 □ Other (Specify) permit, Page 1 Department of Important: If it any injury or o Veterans Cem. 07-28-2010 Cheltenham, MD Funeral Service Lice 22. Name and Address of Facility 21. Signa Strickland Funeral Services 6500 Allentown Rd., Camp Springs, MD 20748 nt 1. Enter the disease, if complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ook, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Advanced Medical resulting in death) Examiner Sequentially list conditions, if any cause immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine attending physician and for use as the burial-transit Sepsis Due to (or as a consequence of). resulting in death) Last Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) Pregnant at time of death Yes 2 No 1 ☐ Yes 2 ☐ Unknown 9 Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, has been sig 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 2 No page 2 🗆 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 XNo 1 🗌 Yes မ 1 Mapatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director; After th completed filled in by the funeral 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pendina 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 3 07/22/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

**JUL 3 0 2010** 

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25358 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month July John William Sobczynski, Jr.  $28^{\circ}$ 20ำัง 9:30 p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3158 Tucker Road Harford Street Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, July 29 7. Age (In vrs. last birthday) g. Birthplace (State or Foreign Funeral Min. 1 <u>930</u> Maryland Months 1 **X**□ M 2 □ F Hours 213-26-6466 79 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Maryland Harford Street 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3158 Tucker Road 21154 U.S.A. items 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces 9 þ 1 Never Married 2 Married Black White, etc. 1 Yes 2 2 X No 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: "natural", Completed 3 ☼ Widowed 4 ☐ Divorced White Year or Dates traumatic event, the Medical 15. Decedent's Education 16b. Kind of Business Industry
Ball Metal 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore, Maryland Eight Years Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ John W. Sobczynski, Sr. Julia C. Janowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3158 Tucker Road, Street, Maryland 21154 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Linda A. Brittain (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State cametery, crematory or other place Sacred Heart of 08/08/10 4 ☐ Donation 5 ☐ Other (Specify) Dundalk, Maryland Cemetery 21. Signature of Funeral Service Licer 22. Name and Ad Yess of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy for Pregnant at time of death Month Day Year 5 Other (specify) been signed by the a should be detached g Unknown g Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has page 2 autopsy performed? Yes 2 No death? 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes s after death.

I Director: After this c မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29c. License 29d. Date signed (Month.

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address

31. Date filed (Month

Day, Year)

of eath (Item 23a) (Type,

32. Registrar's Signature

# Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		State of Maryland / Dep			•	
		- State Registrar Ce	rtificate of Death		3. No. 2010	25359
Physicia Medic		1. Decedent's Name (First, Middle, Last) Lina C. Stann		2. Date of Death Month July	25 2010	3. Time of Death 11:00a M
Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
Funeral		7. Age (In yrs. last birthday)	Frederick  If Under 1 Year   If Under 24 Hrs.  Months   Days   Hours   Min.	8. Date of Birth	Freder:	place (State or Foreign
Director		198-22-7850 1 □ M 2 ☒ F 84 Yrs.  Usual Residence of Decedent	Months Days Hours Will.	Oct. 10,	1925 Vi	rginia
yland f show ed at	tor	10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits
nr 28a- notifie	Director	Maryland Frederick Frederick	10f. Zip Code	100	g. Citizen of What Cou	1 X Yes 2 □ No
with the s 23a c	Funeral	7055 Catalpa Road	21704		Inited Stat	
death r items iner m		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	cify Yes or No-	14. Race - Ameri Black, White,	ican Indian,
s after ral", or Exami	ed by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates.	1 ☐ Yes 2 🖾 No Specify:		Coorie	ite
"natu edical	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work	ing 16	6b. Kind of Business II	ndustry
within i		Elementary/Seconday (0-12) College (1-4 or 5+) life. L	NOT use retired) Homemaker		Own Home	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Mai	iden Surname)	
ould be id Men marke matic	-	William Walker  19a. Informant's Name/Relationship (Type, Print)  19b. Maili	ng Address (Street and Number or Rura	y Lucy B1		Codel
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ge 1 an it of He If iten or oth		20a. Method of Disposition 20b. Place of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cernetery, cre.	osition (Name of matory or other place)	Date 20	c. Location - City or T	
nit. Pag artmen ortant: injury					rederick,	Maryland.
permi Depar Impor any ir		- h. 11 ( ) /   / / / /   S	2 Name and Address of Facility tauffer Funeral Ho 621 Opossumtown P	omes P.A. ike, Fred	erick,Mary	land 21702
hysician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final	0			Approximate interval Between Onset and Death
Medical Examiner	j	disease or condition resulting in death)  a. Due to (or as a consequence of):	dal into	XC 17 01	1	
ed nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury				<u> </u>
be executed sician and burial-transii	cal Exa	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
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To the thospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 [ 4 ☐ Pregnant at time of death 5 [ 9 ☐ Unknown	Ectopic pregnancy Other (specify)		23d. Date of delive Month	very Day Year
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v requi	Completed	High bland Pressing	>	24a. Was an	24b. Were auto	opsy findings available
The lay ate has page 2	Som	ngi piece j. sss		autopsy performe	d? death?	ompletion of cause of 2 📈 No
sician: certific rector,	Be	25. Was case referred to medical examiner? 1 □ Yes 2 ☑ No Hospital: 1 □ Inpution: 2 □ EP/Outputies	26. Place of Death (Check			
g Physical this neral di	te: To	27. Manner of Death 28a. Date of injury 28b. Time o	nt 3 □ DOA	me 5 Residence 28d. Describe how	e 6 Other (Specifinjury occurred	ý) <u> </u>
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al or A s after Il Direct		4 Homicide determined determined 28e. Place of Injury - At home, farm, str	eet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rura State)	al Houte Number,
n 24 houn n 24 houn ne Funera pleted fille	Medical	29a. Certifier (Check only ope 3 Certifying Physician: To the best of my knowledge, death only ope 3 Certifying Nurse Practioner: To the best of my knowledge,	tigation, in my opinion, death occurred at	the time, date and p	place, and due to the ca	ause(s) and manner stated.
North Con th		29b. Signatur and title of certifier	29c. License number D 57 6 4 3		Date signed (Month,	
,,		30. Name and address of person who completed cause of death (Item 23a) (Type, I	D57643 Print) Hirenkumar	Naginbha:	7/26/10 i Shah	21702
Stat	e	31. Date filed (Month, Day, Year) 32. Registrar's Signature	108 700	de sol	s IVID	4170-
Registra	ar	JUL 2 1 2010 Chance B.	gares.			

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 2010 25360 State of Maryland / Department of Health and Mental Hygiene

Alexande	er C. So		1- For State	tate of Mary		artment o e <i>rtificate o</i> a		and Menta		too No		
	Physici		1. Decedent's Name (First, Middle,Last)  2. Date of Death						ath	3. Time of Death		
Medical Examin			Alexander C. Schmidt						July 24, 2		1209 hrs	
7			4a. Facility Name (if not instituti Bartholow Road at M		4b. City, Town, Mount Ai	or Location of D	eath	4c. County of Dea Frederick	th			
Funeral Director						n yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Months Days Hours Min.			Min.	Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign		
	1100101		Usual Residence of Decedent							ountry Nevada		
	permit. Tages I and 2 stood to the downinn /2 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ior	10a. State 10b. County 10c. City, Town or Location							10d. Inside City Limits		
- Cuc			Maryland Fred	Mt	Mt. Airy				1 Yes 2 X No			
Man		Director	10e. Street and Number			10f. Zip Code				10g. Citizen of What Co		
 	s 23a e notif	ralD	4702 Hardwood Court  11. Marital Status 12. Was Decedent									
death.	or item	Funeral				X No						
d d	ural", miner	ò	3 Widowed 4 Divorced 17 Yes, Give Year 1 Yes 2 X No specify: Specify: White									
10.0	n "nati	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)			during most of working life. DO NOT use retired						
0036	er tha	d mg		1		Di	sc Jocl			Enterta	inment	
:15-(	al Hyg red oth nt, the	4.	17. Father's Name (First, Middle Darwin Dean Scl						lame (First, Middle, th Lynn Mo	,		
212	d Ment s mark ic ever		19a. Informant's Name/Relations			19b. Mailing	g Address (St			mber, City or Town, Star	e, Zip Code)	
N S	alth and m 27 i.		Darwin D. Schm	idt/ Fath					, Mt. Air	ry, Marylan		
ore,	of Heartheather tr		20a. Method of Disposition  1 Burial 2 X Crematio		from State	Place of Dispos crematory or ot	her place)	- 1			•	
ltim	artmen ortant ry or o		4 Donation 5 Other Specify: Stauffer Crematory Ind. 7/27/2010 Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility									
ä	ii ii De		Stauffer Funeral Homes P. A.  1621 Opossumtown Pike, Frederick, Maryland 21771									
	/sician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and									
	aminer		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):									
		Ļ	Sequentially list conditions, b.									
		Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Discass or it har it at hillisted									
- T	te be executed ysician and burial - transit		events resulting in death). Last  Due to (or as a consequence of):  d.									
), he exe		Physician/Medical	UNPENDED AMENDED									
Box 68760,	ng phys	In/Me	IF FEMALE: 23b. Was decedent pregnant in t	he 23c. If yes	, outcome of pre		etal death	3 Ectopic pro	egnancy	23d. Date of delive Month	ry Day Year	
9 X 6	attending phy for use as the	sicia	past 12 months?  4 Pregnant at time of death 5 Other (Specify)  1 Yes 2 No 9 Unknown 9 Unknown									
В .	by the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?									
P.O.	signed be det	d by							1 Ye	s 2 🗸 No 3 🗌 Pro	obably 4 Unknown	
of Vital Records,	as been	Completed							24a. Was	osy prior to	utopsy findings available completion of cause of	
Rec	certificate h	E O	performed? death?  1 ✓ Yes 2 No 1 ✓ Yes 2 No									
ital ician:	is certi irector	Be	25. Was case referred to medica examiner?	Hospital:	Inpatient 2	ER/Outpatient		Other N		Residence 6 ✓ Other	er Scene	
of V	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Fouraral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	일	1 ✓ Yes 2 No 27. Manner of Death	28a. Dat	e of Injury th, Day Year) 2010	28b. Time of I		njury at Work?	28d. Describe	how injury occurred		
ion		atio		stigation		1202 hrs		Yes 2 🗸 No		notorcycle collide		
Division		Certification:	3 Suicide 6 Could not be determined (Specify) Local Street				et, factory, offic			Bf. Location (Street and Number or Rural Route Number, City or Town, State) artholow Road at Molesworth Entrance, Mount Airy, MD		
Hosnif			29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
T.		Medical	one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)									
			LOGARD TO THE STATE OF THE STAT			29c. License number O.C.M.E.				July 25, 2010		
			30. Name and address of person who completed cause of death (Item 23a)									
Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201												
	St Regis	tate	31. Date filed (Month, Pry, Year)	7 2010 32. 5	Registrar's Signat	ture	ares					

Evelyn Shade

			Plea	ase Type or Pri					-	_	ble.			
			For State		-		artment of F rtificate of I	lealth and N		00	10 25261			
	Amend.	17.	Registrar 18, 19a, F		7/29/:	10 00	Tillicate of t	Dealli	2. Date of Death	g. No.2 U	10 25361 3. Time of Death			
	Physici		5 velun	Sha.	1.				Month	Day	Year <b>3:08</b> A M			
at he	/Medid Examin		4a. Facility Name (If not institution	-	)		4b. City, Town, or	r Location of Death		4c. County				
- Apple		М	CANDLE LIGHT				EASTON If Under 1 Year		O Data of Distle	Birth 9. Birthplace (State or Foreign				
Н	Funeral Director		5. Social Security Number <b>234–12–2819</b>	6. Sex 7. A	ge ( <i>in yrs.</i> i	<i>last birthd</i> ay) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 11/7/191	Year)	Country)  VA			
			Usual Residence of Decedent						11///151					
	larylar show	ō	10a. State 10b. County	,	10c. City	y, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No			
	the N	Director	MD TAI  10e. Street and Number	LBOT		WIT	TMAN 10f. Zip Code		10	g. Citizen of V	Vhat Country?			
	ath with the Marylan s 23a or 28a-f show		8503 SEWELL PO	OINT ROAD			216	576	τ	NITED	STATES			
	after deat or items	Funeral	11. Marital Status	12. Was Decedent Armed Forces	?	S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - American Indian, k, White, etc.			
36	rs afte	by F	1 ☐ Never Married 2 ☐ Mai 3 ☐ Widowed 4 🛣 Divorced	If Ves Give 4	No		1∐Yes 2 <b>X</b> No	Specify:		Specify	WHITE			
21215-0036	d within 72 hours after death with the Maryland glene. r than "natural", or items 23a or 28a-f show the Madical Evanther must be notified at		15. Deceder	ent's Education est grade completed)		16a. Dece	dent's Usual Occup	pation during most of work		l 6b. Kind of Βι	usiness/Industry			
21	within 7 iene. than "r	Completed	Elementary/Secondary (0-12)		5+)	life.	DO NOT use retired	during most of work d)	mg	OIDI II	IONET.			
	e filed wall Hygie other ti		11 17. Father's Name (First, Middle,	Last)		HUME	MAKER	18_Mother's Nam	e (First, Middle, M	OWN H				
an	should be and Mental s marked o	To Be	RALPH RINKER		Rinke	r		EDITHE		WORSLE				
Maryland	2 should be and Menta Is marked aumatic ev	-				T	ng Address (Street	and Number or Ru						
	r 23 mg g		19a. Informant's Name/Relations GWENDOLYN GWEN CAMERON-D	DAVIS/DAUGHT				WITTMAN						
Baltimore,	0 0 1		20a. Method of Disposition 1 ☐ Burial 2 😾 Cremation		CHE	lace of Dispo emetery, crei SAPEAR	sition <i>(Name of</i> natory or other place <b>E CREMAT</b>	O7/28	Date 2		City or Town, State			
Iţ	+ 는 본 중	13	4 ☐ Donation 5 ☐ Other (5				R . Name and Addre		3/2010   S	TEVENS	VILLE, MD			
Ba	permi Depar Impor any ir		Yniamm	2 4m 81	ime	F	ELLOWS, H	ELFENBEII HARRISON	N & NEWNA	M FUNE	RAL HOME, P.A. D 21601			
			23a, Part 1. Enter the disease, o	or complications that cause st only one cause on each I	d the death						Approximate Interval Between			
	Physician	6 9	Immediate Cause (Final disease or condition	organ	-	Brain	Disea	ere-			Onset and Death			
	/Medical Examiner		resulting in death)	Due to (or	s a consequ	uence of):	/							
		ē	Sequentially list conditions,	b. Face	LE CONTEGUE	ience off:	nuve				6 me			
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1 Al	26	c/m	11:0 D	Slan			5 t years			
60,	be executed ician and ourial-transit		resulting in death) Last	Due to (or as	a consequ	uence of):								
6876		Physician/Medical		d										
9 x	death certificate attending physi for use as the k	/Me	IF FEMALE:	23c. If yes, outcome	e of pregna	ncy				23d Dat	to of delivery			
Box	death e atter d for u	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live birth 4 ☐ Pregnant	2 Fetal	Ideath 3	Ectopic pregnanc Other (specify)	У			te of delivery onth Day Year			
P.O.	it the o	hysi	9 ☐ Unknown	9 ☐ Unknown						1				
S,	The law requires that the death certificate ate has been signed by the attending phys bage 2 should be detached for use as the I	þ	Part II. Other significant conditi	ions contributing to death I	but not resu	ulting in the u	nderlying cause give	en in Part I.			ribute to the cause of death?			
oro	w requir s been s should	eted	Failure h	FAVIOC						2 <b>2</b> No	3 Probably 4 Unknown			
Division of Vital Records,	ne law has b ge 2 s	Completed	,						24a. Was an autopsy perform	-   1	Were autopsy findings available prior to completion of cause of death?			
ta	an: Th tifficate or, pa		25. Was case referred to medica	al				26 Place of Deep		₽No	1 □Yes 2 □No			
Į <	nysick lis cer direct	o Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ient 2 🗆	ER/Outpatier	nt 3 DOA Oth				er (Specify)LTVING			
0 0	ing Pt	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pendir	28a. Date of Inj (Month, Date	ury ay, Year)	28b. Time of Injury	28c. Injur Worl	ry at k?	28d. Describe how					
Sio	ttend death. stor: / the fu	icati	2 ☐ Accident investi	tigation	ium. At ho	mo form str		Yes 2 □ No	20f Location (Ctr	and a mad Alexandr	an an Dumi Dauta Alumba			
<u>&gt;</u>	after after Direc d in by	Certification: To	4 ☐ Homicide determ	mined building, e	tc. (Specif)	y)	eet, factory, office		City or Town,		er or Rural Route Number,			
	ospita hours uneral ly filled		29a. Certifier 1 ertifyi	ing P I ian: To the best	of my know	wledge, deat	occurred at the til	me, date and place	, and due to the ca	use(s) and m	anner as stated.			
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate h, completely filled in by the funeral director, page	ledical	one)	I Examiner: On the basis and manner s	of examina tated.	tion and/or in								
	o o with	Σ	29b. Signature and title of certifie		1 111	1/10	29c. Licens		29	d. Date signe	d (Month, Day, Year)			
	725-2		30. Name and address of person	who completed cause of	death (Ita-	23a) (Time		24198		1/26	12010			
Í	285		5. Haire and agoress of person	Delean-	Botk	iw, C	Print) WP &	579 G	m men	De 7	+ 106, EKSTIN, A			
	Sta	_	31. Date filed (Month, Day, Year,	27 2010 32. Regist	rar's Signal	ture	back				21601			
	Registr	ar	JUL 2	s a Zuiu		1. 0								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar		State of M	larylan	Cei	artment of rtificate of	Deatl	n and N h		Reg. No.		25:	362
Physicia Medic		1. Decedent's Nam		T M.	STR	RAUS	35			2. Date of De	ath 2 <sup>Day</sup>	year 10	3. Time o	
Examin	er	Anne Aru	ndel Medi	e street and number)  Lcal Cente:	r		4b. City, Town, Annapol	is				County of De	undel	
Funeral Director		5. Social Security N 215-09-5	741	Sex 1 □ M 2 <b>y</b> F 7. Ag 9.		ast birthday) Yrs.	If Under 1 Yea Months Days		der 24 Hrs. 's Min.	8. Date of Bir July 13		15 Ma <sup>2</sup>	sirthplace (State of State of	or Foreign
aryland a-f show ified at	ector	Usual Residence of 10a. State Maryland	10b. County  Anne Art	ındel		y, Town or Lo							10d. Inside C	City Limits
with the M 23a or 28 1st be not	Funeral Director	10e. Street and Nur	mber	ourt #201	1	apoli.	10f. Zip Code 2140	)3			10g. Cit	izen of What 0	Country?	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Mari 3 🏋 Widowed	ried 2  Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates.			Was Decedent of If Yes, specify Cul	oan, Mexi	can, Puerto	ecify Yes or No- Rican, etc.)		14. Race - An Black, Wh Specify: W		
rithin 72 hou iene. r than "natu the Medical	Completed	(Spe Elementary/Sec 12	15. Decedent's ecify only highest gronday (0-12)		5+)	(Give life. D	dent's Usual Occu kind of work done O NOT use retired	during m		ing		ind of Busines	s Industry	ain
d be filed w Jental Hygi irked othe itic event, i	To Be	17. Father's Name (						18. Me	other's Nam	e (First, Middle, ena Bak	Maiden S			
nd 2 shoule salth and N n 27 is ma er trauma		19a. Informant's Na		**.			ng Address <i>(Str</i> ee Lake For							
Page 1 arment of Hument of Hument: If iter				☐ Removal from State		emetery, crer as Cre	osition (Name of matory or other pl ematory		7/28		Edg	ewater	or Town, State ,Mary1ar	
permit. Depart Import any inj once,		21. Signatur of Fu	F. Kal	as f		29	2. Name and Add	ons	Islan	d Rd. E	dgew			=
Physician/ Medical		23a. Part 1. Enter 1 shock, or hea Immediate Cause disease or condition resulting in death)	(Final	nplications that cause one cause on each lin	OKE	5- F	er the mode of dy	ing, such	as cardiac d	or respiratory ar	rest,		Approxima Interval Be Onset and	tween
Examiner	ıer	Sequentially list co		Due to (or as				<u>.</u>						
cate be executed physician and s the burial-transit	edical Examiner	cause. Enter Unde Cause (Disease or that initiated event resulting in death)	erlying iinjury es	c. Due to (or as	a consequ	uence of):						•		
		IF FEMALE:		d										
To the Hospital or Attending Physician: The law requires that the death certifics within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as it	Physician/N	23b. Was decedent in the past 12 1 Yes 2 1 9 Unknown	months? No	23c. If yes, outcome  1  Live Birth 4  Pregnant a 9  Unknown	2 Feta	aldeath 3	☐ Ectopic pregna☐ Other (specify)	ncy				23d. Date of o Month		Year
uires that th n signed by uld be deta	by	Part II. Other signin	ficant conditions	contributing to death t	out not res	ulting in the u	underlying cause (	given in P	art I.	23e. Did to		_	to the cause of o	
The law req ate has bee page 2 shoi	Completed									24a. Was autor perfo		prior to death'	autopsy findings o completion of o es 2 \square No	
sician: s certifica lirector,	To Be (	25. Was case referr examiner?  1  Yes 2	ed to medical	Hospital:	iont 2	EB/Outpatie		her:	Death (Check	k o <i>nly</i> one) ome 5 🗆 Resid	donoo 6	Othor /Sn	aciful.	
nding Phy ath. r: After this te funeral c	Certificate: T	27. Manner of Deat  1 Patural 2 Accident	5 Pending Investigation	28a. Date of inju (Month, Da	ıry	28b. Time of injury	f 28c. Inju	_		28d. Describe h			suny)	
ital or Atte urs after de ral Directo lled in by th		3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not determined				eet, factory, office			28f. Location (8 City or Tox			Rural Route Numi	ber,
thin 24 hour thin 24 hour the Funer or the Funer or mpleted file	Medical		Medical Exan	ysician: To the best of niner: On the basis of e rse Practioner: To the	examination	n and/or inves	tigation, in my opir	nion, death the time, o	h occurred at date and plac	t the time, date a	and place, e cause(s	and due to th	e cause(s) and ma as stated.	anner stated.
5 2 5 8		Se	San /	8-Kre	ège	er, m	D DY	48	38		0	7/27	/10	
out	-	SUSAN	14 KX	completed cause of c	death (Item	1 23a) (Type, I	5 Defe	inse	Hw	y Au	nap	olis,	MOZ	1401
Stat Registra		31. Date filed (Mont	th, Day, Year) JUL 282	010 32. Registr	ar's Signai	A. A	arked		/		/			

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

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State of Maryland / Department of Health and Mental Hygiene 2010 25363

			State     Registrar			Cen	tificate of D	Death			Reg.	No.		
			1. Decedent's Name (First, Middle,	Last)						2. Date of D				3. Time of Death
	Physicia		LOUISE		TUCKE	2				$\mathbf{J}_{\mathbf{u}}^{Month}$	20 2	<sup>₽ау</sup> 2010 <sup>Ү∈</sup>	ar	7:45pm <sup>M</sup>
	Medic		4a. Facility Name (if not institution,	give street and number)	TOOKE		4b. City, Town, or	Location	of Death			4c. County of 0	)eath	1
	Examin	er	•											DCE LC
1			DOCTOR'S HOS  5. Social Security Number		(In yrs. last birt	hdayl	LANHAM If Under 1 Year	If Unde	er 24 Hrs.	8. Date of B		PRINCE		place (State or Foreign
	Funeral			1 □ M 2 🏋 F		Yrs.	Months Days	Hours	Min.	(Month, E	Day, Yea	ar)	Count	try)
	Director		226-80-8963 Usual Residence of Decedent		86			L .		AUG.	25.	1923 V	LKG	INIA
ō	at tow	<u></u>	10a. State 10b. County		10c. City, Towr	or Loc	ation						1	0d. Inside City Limits
ylan	-fst-	cto	VA HALIF		HALII									1X☐ Yes 2 ☐ No
Ma	28a Notif	Director		AA	IIVITI	TAA								
h the	a or	al	10e. Street and Number				10f. Zip Code				10g.	Citizen of Wha	t Coun	itry?
wit	is 23	Funeral	6012 CHATHAM R	OAD			24.	558				USA		
Jeat	item Her n		11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	13. W	Vas Decedent of Hi Yes, specify Cubar	ispanic O	rigin? (Spe	cify Yes or No Rican, etc.)	)-	14. Race - A Black, V		
fer So	ami o	by	1 Never Married 2 Marri	1 ☐ Yes 2 🔀 N If Yes, Give	lo	1	☐ Yes 2 🔽 No					Specify: B		
nd 21215-0036 filed within 72 hours after death with the Maryland	tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	3 Midowed 4 Divorced	Year or Dates.			- 103 2 A- 110	Ороон	<i>y</i> .			Specify. D	LAC	·IX
<b>5-(</b>	"nat dica	ple		t's Education st grade completed)	16a.	Deced	ent's Usual Occupa	ation	st of worki	na	16b	. Kind of Busin	ess Inc	dustry
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<b>2</b> ₹	gien ert		8тн				HOUSE	WIFE				PRIVATE		_
nd filed	a Hy	Be	17. Father's Name (First, Middle, Li	ast)				18. Mot	her's Name	(First, Middle	e, Maid	len Surname)		
<u>a</u>		유	JOHN E. COLEMA	N				R	OSA	LOVELA	CE			
<b>Maryland 21215-0036</b> 2 should be filed within 72 hours after	and Me		19a. Informant's Name/Relationsh	ip (Type, Print)	19b	. Mailin	g Address (Street a	and Numi	ber or Rura	l Route Numb	er, City	or Town, State	, Zip C	Code)
_	÷ 12 +5		ORBIE D. ROBE	RTS/DAUGHTER	5	408	207H AVE	ENUE	HYAT	CSVILLI	E.MA	ARYLAND	20	782
<b>6</b> , m	f He	a 9	20a. Method of Disposition		20b. Place of	f Dispos	eition (Name of	:		Date	<del></del>	. Location - Cit		
no age	tment of Healt rtant: If item 2 ijury or other		1 🖄 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S	3 Removal from State	1		atory or other place	i	7 /07		<u>.</u>			
<b>Saltimore,</b> permit. Page 1 and	urtme ortan njur		21. Signature of Fure ral Service Li		I COUNT		INE CHURC			/2010		ALIFAX,		
<b>50</b>	Departmen Important: any injury once.		21. Signatura Si Futigral Service Li	censee			Name and Addres		,			KINS FUN		
_							7474 LAND					R, MARYLA	YND	
			23a. Part 1. Enter the disease, or shock, or heart failure. List o	nly one cause on each line.				_			arrest,			Approximate Interval Between
Ph	ysician/		Immediate Cause (Final disease or condition	Pneu	inom	22								Onset and Death
	Medical		resulting in death)	Due to (or as a	consequence of	of):	iel F		- 0				1	
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rted	d ansit	am	cause. Enter Underlying Cause (Disease or iinjury that initiated events	Stre	ste									
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o <sup>®</sup>	/sicia	ical		L <sub>d</sub> sen	rent	S	•							
<b>68 / 60</b> ertificate be executed	iding physician and se as the burial-transit	/Medical										1	-11-	
Serti	nding use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o								23d. Date of	f delive	erv
<b>BOX</b>	atte	cia	in the past 12 months? 1 ☐ Yes 2 🔀 No	1 Live Birth 2			Ectopic pregnance Other (specify)	:y				Month		Day Year
<b>ກ</b> ຸ ສຸ	/ the	Physicia	9 Unknown	9 🗌 Unknown								ļ <u>.</u>		
that the	əd by deta	P.	Part II. Other significant condition			n the ur	nderlying cause giv	en in Par	t I.	23e. Did	tobacc	o use contribut	e to th	e cause of death?
S, F	sign d be	d by	Empha	ed theri						1 1	Yes	2 <b>X</b> No 3	Prot	oably 4 🗆 Unknown
	hould	ete	100.000	ندورية لم	m									
§	ask e2s	ldu	7 m	00 W-40						24a. Wa aut	opsy	prior	to cor	osy findings available mpletion of cause of
VITAI KECOFOS, ysician: The law requires	ate l	Completed					7070				formed 2			2 🗆 No
	ertific ctor,	Be	25. Was case referred to medical examiner?				26. Pla	ace of De	ath (Check	only one)				
Ysic	dire	2	1 ☐ Yes 2 🐼 No	Hospital: 1 Kinpatier	nt 2 🗆 ER/Ou	tpatient	t 3 ☐ DOA Othe	er: 4 🗆 1	Nursing Ho	me 5 $\square$ Res	sidence	6 Other (S	pecify	)
or P	ter th		27. Manner of Death	28a. Date of injury (Month, Day,		ime of njury	28c. Injury work			28d. Describe	how in	jury occurred		
o igi	ath. r:Aff ne fui	ica	1 Natural 5 Pending 2 Accident Investig	ation		., ,		Yes 2	□ No					
Atte	er de ecto by th	Certificate:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	28e. Place of Injur		rm, stre	et, factory, office					and Number or	Rural	Route Number,
DIVISION tal or Attendir	s afte			building, etc.	(ъреспу)					City or To	wn, Sta	ate)		
spit	hour Iners d fille	lica		Physician: To the best of m										
e K	within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the atten completed filled in by the funeral director, page 2 should be detached for u	Medical		caminer: On the basis of exa Nurse Practioner: To the b										
To th	withi To #		29b. Signature and title of certifier				29c. License					Date signed (M		
	5		> mule min	- Applem	, me	)	D00	76	19 L	· =	7	- 211	20	10
	3		30. Name and address of person w								I,	, ,		
	20		MUKEMIL	Mydell	S. W	~	12200	ANIA	14-001	is Roa	2 5	wite m	96	len late MA
	Stat	e	31. Date filed (Month, Day, Year)		s <b>g</b> nature		1	11141	neol	P . W.	1	W. 1 - 11	<del></del>	i-rivine, ris
		25	1111 CA CA 2011	[ [ ]d .	M Ba	A Print								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 20 10 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 2010 8:49 PM Florence Townsend Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 25432 Colton Point Road St. Mary's Morganza If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) October 21, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Months Hours Min. Tennessee Director 88 Yrs 215-76-6098 1921 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No St. Mary's Morganza Maryland 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 25432 Colton Point Road 20660 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married þ 1 Yes Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Macain once. 1 Yes 2 X No Specify. Specify: White Completed 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Daniel Ingram Kate Cornett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tamsey L. Herbert / Daughter 25432 Colton Point Road, Morganza, MD 20660 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State August 5, 2010 4 Donation 5 Other (Specify) Charles Memorial Gardens Leonardtown, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Tetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4  $\square$  Nursing Home 5 Residence 6  $\square$  Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending work's 1 Tes 2 No Accident Investigation 3 Suicide
4 Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature a 2010 completed cause of death (Item 23a) (Type, Print) 30. Name and addre 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Wanda C. Williams 1:45 P <sup>M</sup> July. 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9003 LeVelle Drive Chevy Chase Montgomery 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) eb. 13,1970 1 🗆 M 2 🗶 F Months Days Hours Min. Director Washington, DC 578-88-5395 Feb. 40 Usual Residence of Decedent 28a-f show ms 23a or 28a-f shorements the second 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland | Germantown Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20876 United States 13018 Woodcutter Circle Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc. ō δ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 'natural", Specify: Black Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Private Billing Coordinator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Department of Health and Ment Important: If item 27 is marker any injury or Attach Edith Davis Warren C. Wiliams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13018 Woodcutter Circle, Germantown, Maryland 20876 Dustin Williams/Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Surial 2 Cremation 3 Removal from State Donation 5 Other (Specify) 07/29/2010 Suitland, Maryland Lincoln Cemetery ature of Funeral Service License 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Avenue, NW, Washington, D.C. 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Breast Cancer Physician/ disease or condition resulting in death) 1Year4Months Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death
Unknown Month Day Year signed by the a P.O. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed' Yes 2 K No 2 🗌 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Mother's Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\bar{\mathbb{M}}\) Other (Specify) 1 Yes 2 X No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work 1 Tes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) D37236 July 28, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Caroly B. Hendricks, M.D. 6410 Rockledge Drive Suite506, Bethesda, Maryland 20817

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25366 Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month JULY LINDA D WASHINGTON 2010 Medical 4:01 A M 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 10113 WOOD LAUREL WAY MITCHELLVILLE PRINCE GEORGE'S 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 TF Months Days Hours Min. AUG . 3 WEST VIRGINIA Director 577-64-0950 63 T946 Usual Residence of Decedent 28a-f show er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 □ No MD PRINCE GEORGE'S MITCHELLVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10113 WOOD LAUREL WAY 20721 USA hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK Completed 3 Widowed 4 X Divorced Specify Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) **2YRS** DAY CARE PROVIDER **ENTREPRENEUR** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 UNKNOWN ALICE M. BREWINGTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 43590 PURPLE ASTER TERRACE LEESBURG, VIRGINÍA 20176 LEMUEL R. CHANCE/SON Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State REST HAVEN CEMETERY 8/7/2010 DUNN, NORTH CAROLINA 4 ☐ Donation 5 ☐ Other (Specify) Sissetture of Funeral Sarvice Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death "Priysician» BREAST CANCER disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine If any, leading to immediate cause. Enter Underlying Due to for as a consequence of, physician and the burial-transit requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month 1 Yes 2 No 9 Unknown page 2 should be detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Ty Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician; The law has autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 1 🗌 Yes 2**X** No မ Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1X Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D23743 JULY 28, 2010

State Registrar

Barks

7525 GREENWAY CENTER DRIVE #205 GREENBELT, MARYLAND 20770

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registraris Signature

MARTIN WELTZ M.D.

31. Date filed (Month, Day, Year)
JUL 2 8 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** YVONNE WALKER JULY 5:25 P M 24 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HARTFORD MEMORIAL HOSPITAL HAVRE DE GRACE HARTFORD 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1 M 2 F Days Hours Months Yrs. Director 217-70-3393 ARIZONA Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov ir then "natural", or iteme 23a or 28a-f ehov the Madical Examinar must be notified at 1 X Yes 2 □ No Director MD PRINCE GEORGE'S BOWIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16601 SYLVAN DRIVE 20715 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 1 Never Married 2 ☐ Married Maryland 21215-0036 <u>ک</u> 1 ☐ Yes 2 🔯 No Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry is marked other then Elementary/Secondary (0-12) College (1-4or 5+) 12th SECURITY OFFICER GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) CLAUDIUS WALKER FRANCES ADAMS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHELLE MALLOY/SISTER it of Health 16601 SYLVAN DRIVE BOWIE, MARYLAND 20715 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages ' 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Injury or 4 ☐ Donation 5 ☐ Other (Specify) RIVERDALE CREMATORY 7/29/2010 RIVERDALE, MARYLAND 21. Sur ature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician Myoc /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a conseque e o Examiner attending physicien and for use as the burial-translt resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) the o 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Š Completed 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy performed? Yes 2 No certificate Vital 1 ☐ Yes To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA ŏ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident hours after deat 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) WATSON D0070234 30. Name and address person who completed cause of death (Item 23a) (Type, Print)

ERIN WAIBON, MD 501 5. UNION AVE HAVE de GRACE, MD. 21078

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State		artment of Health and M tificate of Death		-21111	25368
			Registrar  1. Decedent's Name (First, Middle, Last)	061	tineate of Beatif	Reg. 2. Date of Death	No.	3. Time of Death
	Physicia Medic		AUDREY J. WARNER			JULY 2	3, 2010	12:30P <sup>M</sup>
	Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Deat	
			PRINCE GEORGE'S HOSPITAL  5. Social Security Number 6. Sex 17, Age (In yrs. last b)	irthday)	CHEVERLY  If Under 1 Year   If Under 24 Hrs.	8. Date of Birth		SEORGE 'S thplace (State or Foreign
	Funeral Director		227-48-9.692 1□M2XF 72	Yrs.	Months Days Hours Min.	5 / 25 / 19	$\frac{c}{3}$ 8 VIF	RGINIA
	d iow it	_	Usual Residence of Decedent  10a. State 10b. County 10c. City, To	wn or Loc	cation			10d. Inside City Limits
	arylan a-f sh ffied a	Director	MD MONTGOMERY SILVE					1 🖾 Yes 2 🗆 No
	the Mi or 28 e noti	Dir	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Co	ountry?
	s 23a	Funeral	9713 DILSTON RD		20903	UN	ITED STA	ATES
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status  1  Never Married 2  Married  3  Wildowed 4  Noivorced  12. Was Decedent Ever in U.S. Armed Forces?  1  Yes 2  No If Yes, Give Year or Dates.	l1	Nas Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto □ ☐ Yes 2 ☑ No Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: BLA	e, etc.
2-0	hours 'natur dical I	olete	100.0.000		dent's Usual Occupation kind of work done during most of worki	ng 16	o. Kind of Business	Industry
21215-0036	within 72 giene. i <b>er than</b> " <b>, the Me</b> i	Completed	Elementary/Seconday (0-12) College (1-4 or 5+)	life. D	O NOT use retired)		^**********	I.C.
Q 2	filed wit al Hygie d other event, th	a l	12th		TRAVEL CLE	KK Jul	OVERNMEN den Surname)	N.1.
ılan	d be fil hental irked tic ev	잍	UNKNOWN		LOTTIE	SIMMS _	·	
, Maryland	d 2 should be file alth and Mental 1 27 is marked c	Î	19a. Informant's Name/Relationship (Type, Print) AUDREY N. WARNER/DAUGHTER 8	9b. Mailin 8 3 0	ng Address (Street and Number or Rura PINEY BRANCH R	l Route Number, Cit .D., SIL	y or Town, State, Zij VER SPR]	O Code) 20903 [NG MD.
Baltimore,	Page 1 and lent of He ut If item ry or other	ľ	1 № Burial 2 Cremation 3 Removal from State cemei	tery, cren	sition (Name of natory or other place)  N CEMETERY 8/4		c. Location - City or OCKVILLE	
Balti	permit, Page Department o Important: If any injury or once.		21. Signature of Funeral Service (icense)	22	Name and Address of Facility CAP	TTOI MOI	TILADV	
			23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	ot ente	er the mode of dying, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)  a. Due to (or is i consequence)	<b>M u</b> , ⇒ of):	sur swaren	the	ouncest	days.
	- t	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	of):	energine a pro	7		1 all 1
	ate be executed hysician and the burial-transit	edical Examiner	Cause (Disease or ilinjury that initiated events resulting in death) Last C. Due to (or as a consequence	e of):	nswn	220		guis
9	cate be ex physician the buria	dica	d					
P.O. Box 687	ath certific attending   for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death		Ectopic pregnancy Other (specify)		23d. Date of de Month	livery Day Year
s, P.O.	requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting	g in the u	inderlying cause given in Part I.			the cause of death?
Division of Vital Records,	<b>sician:</b> The law requ s certificate has beel lirector, page 2 shou	Completed				24a. Was an autopsy performer	prior to death?	topsy findings available completion of cause of
Ea	sian: T ertifica ector, p	Be	25. Was case referred to medical examiner?		26. Place of Death (Check			
Ž	Physic this or al dire	은	Inpatient 2 L ER/C	Outpatien		me 5 Residenc 28d. Describe how i	e 6 Other (Spec	ify)
0 0	ding th. After funer	cate	Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident Investigation	injury	work?  M 1 Yes 2 No	26d. Describe flow i	njury occurred	
)ivisio	I or Attending Physician: s after death. Director: After this certific d in by the funeral director,	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	eet, factory, office	28f. Location (Stree City or Town, S	t and Number or Ru tate)	ral Route Number,
_	To the Hospital or within 24 hours afti to the Funeral Dir completed filled in	Medical	29a. Certifier (Check only one)  12 Certifying Physician: To the best of my knowledge only one)  13 Certifying Nurse Practioner: To the best of my knowledge only one)	/or invest	tigation, in my opinion, death occurred at	the time, date and p	lace, and due to the	cause(s) and manner stated.
	To the vithin com	_	29b. Signature and title of certifier  June A. M. M.	D	29c. License number  D 45341	29d	Date signed (Monti	h, Day, Year)
	AN S	p	30. Name and adoless of person who completed cause of death (Item 23a)		George Hosp	retal C	Leverly	MD
	Stat Registra		31. Date filed (Month, Day, Year)  JUL 3 0 2010  32. Registrar's Signature	arks	1			

		•	For State Of IVIA  State Registrar	Cer	tificate of L			Reg. No.	
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				2. Date of De. Month <b>JULY</b>		3. Time of Death
_	Medic	al	MARJORIE ELIZABETH WENZEL  4a. Facility Name (if not institution, give street and number)		4b City Town or	r Location of Death		25 2010	
-10	Examin	er	STELLA MARIS HOSPICE			LLE TIMO		BALTIMOI	
	Funeral Director		5. Social Security Number 219–14–2219 6. Sex 1 \( \text{ M} \) \( \text{X} \) F 7. Age	(In yrs. last birthday) <b>86</b> Yrs.	If Under 1 Year Months Days		8. Date of Bird (Month, Da DEC 3,	th g. E	Birthplace (State or Foreign
	and show	or	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Loc	cation	_			10d. Inside City Limits
	Maryla 28a-f s otified	Director	MARYLAND ANNE ARUNDEL	ANNAPOLIS	5				1 ☐ Yes <b>X</b> ☐ No
	h the		10e. Street and Number		10f. Zip Code			10g. Citizen of What	
	ath wit	Funeral	940 ASTERN WAY #409  11. Marital Status 12. Was Decedent Ev	verin IIS 13 V	21401	ispanic Origin? (Sp	ecify Yes or No-	UNITED STA	ATES nerican Indian,
Maryland 21215-0036	s filed within 72 hours after death with the Maryland tal Hygiene. set other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1  Never Married 2  Married	lo If	Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)	Black, Wi Specify: Wi	nite, etc.
15-0	72 hou "natu edica	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k		ation during most of work	ring	ss Industry	
7121	within 7 giene. er than , the M	Con	Elementary/Seconday (0-12) College (1-4 or 5+	HOMEN	O NOT use retired)  [AKF:R			OWN HOME	
br	filed wall Hyg dothe		17. Father's Name (First, Middle, Last)			18. Mother's Nam	ne (First, Middle,	Maiden Surname)	
ylaı	ild be fil Mental narked atic eve	욘	HAROLD LEROY VAN LANINGHAM			GRACE E	LIZABETI	I OSWALD	
Mar	2 should be Ith and Men <b>27 is marke</b> r <b>traumatic</b>		19a. Informant's Name/Relationship (Type, Print)	ı	•			r, City or Town, State,	
ē,	and Heal tem (	8 /	JOHN R. FRAZIER, JR./SON  20a. Method of Disposition	20b. Place of Dispos	sition (Name of		Date	ARYLAND, 2	
Baltimore,	permit. Page 1 Department of Important: If i any injury or o		1 ☐ Burial 2 🗶 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	CHESAPEAK CENTER	R, LLC	JULY		STEVENSVII	LLE, MARYLAND
Ba	Dep Imp		SEAU	I CR	REMATION	AND FUNEI	RAL CARI	HELFENBEIN E,P.A.,814	BESTGATE ROAL
			23a. Part 1. Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line.	he death. Do not ente	er the mode of dying	g, such as cardiac	or respiratory an	rest,	Approximate Interval Between
~~1	Physician/	2 3	Immediate Cause (Final disease or condition CONGESTI	VE HEART I	AILURE				Onset and Death
-	Medical Examiner		resulting in death)  Due to (or as a	consequence of):					
		ner		consequence of):					
	suted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events  c.						
	e exec cian al vurial-t		resulting in death) Last Due to (or as a	consequence of):					
760	ificate be executed ig physician and as the burial-transit	<b>Aedical</b>	d						
89	certifi anding use as	M/ng	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live Birth 2		Ectopic pregnanc	27		23d. Date of	delivery
Box 68760	requires that the death certific been signed by the attending should be detached for use as	Physician/N	in the past 12 months?  1 Yes 2 No 4 Pregnant at 19 Unknown		Other (specify)	, y		Month	Day Year
P.O.	at the	/ Ph	Part II. Other significant conditions contributing to death but	t not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	obacco use contribute	to the cause of death?
S, F	uires the signer of signer	ed by					1 🗆	Yes 2 No 3 🗆	Probably 4 🗆 Unknown
örc	w requisits pee	Completed					24a. Was		autopsy findings available o completion of cause of
Rec	sician: The law s certificate has b lirector, page 2 s	Com					_ perfo	rmed? death	
ita	ician: certific rector,	Be	25. Was case referred to medical examiner?		Otho	ace of Death (Chec			
of V	y Phys er this eral di	e: To	27. Manner of Death 28a. Date of injury		t 3 🗆 DOA   28c. Injury	4 ∐ Nursing Hey y at		dence 6 <b>X</b> Other (Sp now injury occurred	ecify) HOSPICE
on (	ath. ir: Afte	ficat	1 X Natural 5 ☐ Pending (Month, Day, 2 ☐ Accident Investigation	Year) injury	M 1 □	? Yes 2 □ No			
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury building, etc.	y - At home, farm, stre (Specify)	eet, factory, office		28f. Location (S City or Tow	Street and Number or F vn, State)	Rural Route Number,
Ω	ospital hours neral I		29a. Certifier 1 Certifying Physician: To the best of m						
	the Hc nin 24 the Fu npleter	Medical	(Check only one) 3 Medical Examiner: On the basis of examiner on the basis of examiner on the basis of examiner. To the basis of examiner on the basis of examiner.						
	vitl con		29b. Signature and title of certifier	29d. Date signed (Mb)	nth, Day, Year)				
J	1945		30. Name and address of person who completed cause of dea	ath (Item 23a) (Type P	1 /3/19	1172	•	1100	210
	il.			ULANEY VAL		TIMONIUM	1, MD 21	093	
	Stat Registra		31. Date filed (Month, Day, Year)  32 Registrar	's Signature	ale				

5:30 р.т.

JULY 25, 2010

MARJORIE WENZEL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 6:00 a  $_{\rm M}$ Month July Physician/ Year 2010 Ruth Marie Willey Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Chesapeake Woods Center Cambridge Dorchester 8. Date of Birth (Month, Day March 9 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours 1 M 2 XF Year 1929 Maryland 81 Director 215-26-6133 Usual Residence of Decedent 10a. State 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d, Inside City Limits 72 hours after death with the Maryland Director Cambridge MD Dorchester 1 X Yes 2 ☐ No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21613 USA 905 Central Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes If Yes, Give 2 X No white 1 ☐ Yes 2 X No Specify. Specify: "natural", 3 XWidowed 4 Divorced Year or Dates Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natur ury or other traumatic event, the Medical. 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) assembler electronics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Mary Cousins Caleb A. Simmons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 417 Atlantic Ave., Cambridge, MD 21613 Phyllis J. Lee daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H 1 X Burial 2 Cremation 3 Removal from State Important: If any injury or Dorchester Mem. Park 7/29/10 Cambridge, MD 4 Donation 5 Other (Specify) 21. Signatule of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as a reliac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical o or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Day to fur as a nonsequence of Hospital or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last is certificate has been signed by the attending physician director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No.

9 Unknown 4 Pregnant g Month Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? After this certificate 2007 ACH 25. Was case refe red to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Sursing Home 5 Residence 6 Other (Specify) 2 100 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director, After this completed filled in by the funeral is 28a. Date of injury (Month, Day, Year) 27. Manner of De th 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Aatural work? 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the 29b. Signature and title of 29d. Daté signed (Month, Day, Year) 30. Name and andress of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 015

31. Date filed (Month, Day, Year)

D.O

32. Registrar's Signature

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 24 JULY 04024M Taressa Ann Wanex 2010 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CAMBRIDGE DORCHESTER GENERAL HOSPITA DORCHESTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Nov. 24,1965 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Months Days Hours Min. 1 □ M 2 F Maryland 217-94-2773 Director Usual Residence of Decedent 10c. City. Town or Location 10d, Inside City Limits 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Eventinal must be notified at 1 X Yes 2 □ No Director Maryland Dorchester Secretary 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21664 127 Poplar Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 🔯 No Specify White Specify: 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Secondary (0-12) 12 College (1-4or 5+) Instructor Driver Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Beverly Eleanor Cox Richard Leo Wanex ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 127 Poplar Street, Secretary, MD 21664 Steven G. Wanex/Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date injury or 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Our Lady Of Good Counsel 7/29/2010 Secretary, Maryland 4 ☐ Donation 5 ☐ Other (Specify) uture of Funeral Service License e 22. Name and Address of Facility Zeller Funeral Home, P. O. Box 207 106 Main Street, East New Market, MD 21631 23a. Fart/. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Box 68760. Physician/Medical IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the a P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 3 Probably 4 ☐ Unknown icate has been si , page 2 should b 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No Division of Vital After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manger of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? (Month, Day, Year) 1 XNatural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a, Certifier 🗠 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year,

Registrar
DHMH 17 Rev 1/2001

State

NANEX

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

75R 9 50 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 1 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month July Physician/ Day 30 <sup>Y</sup>2010 9:00 PM James George Wallace Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 10574 Worton Rd Kent Worton 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗓 M 2 🗆 F Months Days Hours Min. Biloxi. MS Director 81 62-22-7515 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 XNo Worton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21678 10574 Worton Road items ; 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian Armed Forces'
1 A Yes 2 If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ö 1 Never Married 2 Married Completed by 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give "natural", Specify: 3 Divorced 4 Divorced n/a Year or Dates. White 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic Automotive permit. Page 1 and 2 should be filed be Department of Health and Mental Hyg Important: If item 27 is marked oth any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Agnes Bertha Kurlinski James George Wallace Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10574 Worton Road Worton, MD 21678 Joan O. Wallace 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation 8-2-10 Stevensville, MD Funeral Service 22. Name and Address of Facility Fellows, Helfenbein & Newnam 30 Speer Road Chestertown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between LUNG Onset and Death Physician/ 0412x disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy signed by the atte in the past 12 months? Pregnant at time of death 2 NO g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 death? certificate 1 Yes Yes 25. Was case referred to edical Be 26. Place of Death (Check only one) examiner? Other: Certificate: To 2 TINO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) this 27. Man or of Death filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of After t 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending s after death. 1 Yes 2 🗆 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, 24 hours Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of 29d. Date signed (Month, Day, Year) 10 3605 Name and address of person who completed cause of death (Item 23a) (Type, Print) M S State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2010 Physician/ July 23 Shirley Joan Evans Wilson 6:45 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 200 Double Creek Rd. Queen Anne's Chestertown If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗓 F Hours 6/24/1939 Director 215-36-0026 71 Usual Residence of Decedent items 23a or 28a-f show ner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Queen Anne's Chestertown 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 200 Double Creek Rd. 21620 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Bookkeeper Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Henry Evans, Sr. Daphne Dennis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Wilson/ Husband 200 Double Creek Rd. Chestertown, MD 21620 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation 7/26/2010 Stevensville, MD 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Fellows, Helienbein & Newnam Funeral Home 130 Speer Rd. Chestertown, MD 21620 23a. Part 1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on each or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Thereoid Cancer Metastatic Physician/ disease or condition MODIVS Medical resulting in death) Due to (or as a consequence of Examiner cause that yield the cause cause in the cause of the caus Due to (or as a consequence of): sician and burial-transit Exam or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No for Year Month detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be del Completed by Hx Basal Cell Skin Candov: Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, to 25. Was case referred to medical l & 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\frac{\pi}{4}\) Residence 6 \(\sum \) Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 14 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 [ To the only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0050996

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician /Medical JAMES 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSPITAL CENTER RIVER 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 **2** M 2 ☐ F Months Days 427-40-6835 Director Mississippi Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Ne dical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? 21620 USA out Was Decedent Ever in U.S. Armed Forces? 1 Mes 2 No If Yes, Give Year or Dates: 1950-1951 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ■No Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced Black 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Decedents obsult Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mae Taylor .ola 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chestertown, MD 21420 adine W.fe AVE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Hurlock, MD 21620 7/30/2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Recurrent Meterstatic Adence develorma Physician years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 12 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has b rector, page 2 sh 24a. Was an 24 No 1 □Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No completely filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I HI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0050996

Registrar

State

100

32. Regist ar's Signature

Chestertown MO 21620

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M		artment of Health and		2010	2537
	Physicia	ın/	Registrar  1. Decedent's Name (First, Middle, La  Linda M. Grispin	,	06/	inicate of Death	2. Date of De. Month July	Ath Day 2010	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, giverally 149 Berrywood Dr	e street and number)		4b. City, Town, or Location of De	ath	4c. County of Deat	
	Funeral Director	Г	5. Social Security Number 6. 5		e (In yrs. last birthday) 55 Yrs.	If Under 1 Year	lrs. 8. Date of Birl	th 9. Bir	thplace (State or Foreig untry) nsylvania
	yland f show ed at	tor	Usual Residence of Decedent  10a. State  10b. County		10c. City, Town or Lo	_			10d. Inside City Limits
	h the Mar ka or 28a- be notifi	al Director	MD Anne Ar  10e. Street and Number		Severn	a Park	-	10g. Citizen of What Co	1 Yes 2X N
036	is filed within 72 hours after death with the Manyland tal Hyglene.  ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ed by Funeral	149 Berrywood D  11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent B Armed Forces? 1  Yes 2  If Yes, Give Year or Dates.	No I	21146  Was Decedent of Hispanic Origin? f Yes, specify Cuban, Mexican, Pur  □ Yes 2 ▼ No Specify:	(Specify Yes or No- erto Rican, etc.)	USA  14. Race - Ame Black, White Specify:	
Maryland 21215-0036	vithin 72 hou liene. I <b>r than "nat</b> u <b>the Medica</b>	Completed	15. Decedent's f (Specify only highest gr Elementary/Seconday (0-12)		(Give life. D	tent's Usual Occupation kind of work done during most of w O NOT use retired) Reting Executive	_	16b. Kind of Business Direct Ma	•
yland ;	should be filed with n and Mental Hygier 7 is marked other t raumatic event, th	To Be	17. Father's Name (First, Middle, Last) George Grispin	<u>.</u>		18. Mother's N	lame (First, Middle,	Maiden Surname)	7
, Mar	1 and 2 should be of Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (1980)  Robert M. Bennet		nd 149	ng Address (Street and Number or Berrywood Drive			
Baltimore,	permit, Page 1 e Department of I Important: If ite any injury or ot once,		20a. Method of Disposition  1	ify)	Metro Cre	matory, INC.	Ly 26, 2010	20c. Location - City or Baltimore,	MD
g	permi Depa Impo any is		21. Signature of Fureral Service Licen	un	<u> </u>	Name and Address of Facility <b>rranco &amp; Sons,</b> 1 5 <b>Ritchie Hwy</b> ,	Seve	rna Park, M	neral Home D 21146
~ .	Physician/ Medical Examiner		23a. Part Finter the disease, or comshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a.		er the mode of dying, such as cardi	ac or respiratory arr	est,	Approximate Interval Between C et and Death
	cuted nd rransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	с	consequence of):				
00	te be e nysiciar ne buri	dical	resulting in death) Last	Due to (or as a	consequence of):				
. BOX 08/	The law requires that the death cartificate be executed rate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 W No 9 □ Unknown	23c. If yes, outcome of 1 Live Birth 4 Pregnant at 9 Unknown	2 🗌 Fetal death 3 🗌	Ectopic pregnancy Other (specify)		23d. Date of del Month	ivery Day Year
JS, P.O.	luires that th in signed by uld be deta	by	Part II. Other significant conditions of	contributing to death be	ut not resulting in the u	nderlying cause given in Part I.	23e. Did to	obacco use contribute to	the cause of death?
Records,	The lav ate has page 2	Completed					24a. Was a autop perfor	prior to death?	topsy findings available completion of cause of
VItal	sician certifi rector	m	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑No	Hospital:		26. Place of Death (CI			
0	g Phy er this eral d	e: To	27. Manner of Death	28a. Date of injur	ent 2 ER/Outpatien y 28b. Time of	28c. Injury at		ence 6 Other (Speci ow injury occurred	ify)
VISION	ten deat tor: the	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	ne l	ry - At home, farm, stre	work? 1 ☐ Yes 2 ☐ No eet, factory, office	28f. Location (S City or Tow.	treet and Number or Run	ral Route Number,
בֿ בֿ	Io the Hospital or At within 24 hours after or To the Funeral Direct completed filled in by	edical C	29a. Certifier (Check (	sician: To the best of	my knowledge, death c	occured at the time, date and place	, and due to the cau	use(s) and manner as sta	ted.
:	o the hithin 24 p the Formplet	Me	only one) 3 Certifying Nur 29b. Signature and title of certifier	se Practioner: To the l	pest of my knowledge, o	eath occurred at the time, date and	place, and due to the	e cause(s) and manner as	stated.
	- 3 F ŏ		Susan H	Kreege	DR. MIS	D44830	5	07/26/	10

State Registrar elense Huy Annapolis, MD 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 20 1 0 10-06029 25376 Koron Tarshawn Adams 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 3. Time of Death Month Medical Examiner Korron Todd-Shawn 1517 hrs Adams August 11, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Johns Hopkins Hospital 5 Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months 0.5 Days 24 Hours Director 1 X M 2 F unk Country) 02/18/2010 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or items 23a or 28a-f show must be notified at once. 1 X Yes 2 No N/A Baltimore hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1632 Malvern Street S A .

14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2 X No 1 Yes 1 Yes 2 No specify: 3 Widowed 4 Divorced f Yes, Give Year Specify: Black \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages I and 2 should be filed within 72 P Department of Health and Mennal Hygiene. Important: If item 27 is marked other than "" injury or other traumatic event, the Medical E 5-0036 N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Corey T. Adams Tierra S. Tyson 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Johnson(great-Aunt) 4791 Byron Rd., Pikesville, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place 1 X Burial 2 Cremation 3 Removal from State Mt. Carmel Cem. 08/18/10 Baltimore, MD Ponation 5 Other Specify 21 Signature of Funeral Service Lide <sup>2</sup>Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD PA 21217 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Retween Onset and /Medical Death Sudden Unexplained Death In Infancy (SUDI) Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be executed and - transi Physician/Medical 23a,27,28a-f per me g908 10-14-10 vt the attending physician ed for use as the burial -X UNPENDED AMENDED 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death Box ( 5 Other (Specify) signed by the atte I be detached for u 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed After this certificate has been if 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed death? ✓ Yes 2 No 1 🗸 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Other Nursing Home 5 Residence 6 Other 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 X No To the Funeral Director: completely filled in by the f fd 2:27pm fd 8-11-10 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 6 X Could not be Suicide 1632 Malvern Ave. Balto.Md. determined (Specify) 4 Homicide house 29a. Certifier 1 (Check only 1 one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated g 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Ø

DHMH 17 Rev 1/2001

**OCME 2006** 

State 31. Dalei G (Monto)
Registrar

29b. Signature and title of certifier

( Ino La

Ana Rubio MD.

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

· j

**ORIGINAL** 

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

August 12, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Augus 12:10 PM Verlene 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Randlestown Season Hospice-NW Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign  $V^{Country)}_A$ **Funeral** 1 🗆 M 2 🕱 F Days Hours 76 227-42-2179 Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10c. City, Town or Location Baltimore 10d. Inside City Limits Director N/A MD 1 ☐ Yes 2X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 5530 Nome Ave USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, African Specify: American 1 Never Married 2 Married 2 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event than Elementary/Seconday (0-12) College (1-4 or 5+) Sinai Hosp. E.R. Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Davenport Ellen Jones 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eva Darlene Anderson 5530 Nome Ave, Balt., MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place. 1 Burial 2 Cremation 3 Removal from State 8/20/10 King Memorial Pk Balt. County,MD 4 Donation 5 Other (Specify) 21. Signature | Funeral Pervice Licens 22. Name and Address of Facility Hari P. Close F. Svs. PA 5126 Belair Rd, Balt., MD 21205-5105 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final End-Stage Alzheimers Onset and Death Friysician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to introduct cause. Enter Underlying Examiner July to for as a nonsequence of the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnapt 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Year Pregnant at time of death 1 Yes 2 2 Unknown After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? ☐ Yes 2 No 2 🗌 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ₺ No 4 Nursing Home 5 Residence 6 Other (Specify) မ Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated DODS7465 (Item 23a) (Type, Print) AV- 5- 203 - Baltimore, MD. 212 09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rajapatio M.D 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	Stat	e of Ma	ryland /		artment of F tificate of D				giene Reg. N	ZUIU	25378	
			Decedent's Name (First, Middle)	Last)						2. Date of De	ath		3. Time of Death		
F	hysicia Medio		Frances			_					Month 08-0	6-2	010 Year	1:30p <sup>M</sup>	
	Examin	er	4a. Facility Name (if not institution, 4908 Gunth)	_				4b. City, Town, or Balti				4c	. County of Death		
~ · · · · · · · · · · · · · · · · · · ·	uneral			6. Sex		(In yrs. last bir	thday)	If Under 1 Year		der 24 Hrs.	8. Date of Bir		N/ 9. Birt	A hplace (State or Foreign	
	irector		216-24-3875	1 🗆 M 2 🗆	x 8	35	Yrs.	Months Days	Hours	s Min.	(Month, Day, Year) Country) 07-29-1925 Md				
ъ	t t	_	Usual Residence of Decedent  10a. State 10b. County			10c. City, Tow	n or Loc	eation						10d. Inside City Limits	
arylar	a-f sh ified	ecto		N/A				more						1 <b>□</b> X∕es 2 □ No	
the M	or 28 e not	Dir	10e. Street and Number					10f. Zip Code				10g. Ci	itizen of What Co	untry?	
with r	is 23a nust t	Funeral Director	3509 Dennl	yn Rd.	·			212	15				U.S	. A	
death	r item iner n		11. Marital Status 1 ☐ Never Married 2 ☐ Marr	Arme	Decedent Eved Forces?		13. V	Vas Decedent of H Yes, specify Cuba	ispanic ( ın, Mexid	Origin? (Spe can, Puerto	cify Yes or No- Rican, etc.)		14. Race - Amer Black, White		
036 s after	aľ, o Exam	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes	Yes 2 A s, Give or Dates.	40	1	☐ Yes 2 ☐ No	Spec	cify:			Specify: Bla	ack	
<b>21215-0036</b> within 72 hours after a	"natu dical	Completed	15. Deceder (Specify only highe	t's Education		16a	a. Deced	ent's Usual Occup	ation	ost of worki	na	16b. K	(ind of Business I	ndustry	
<b>121</b>	than than	mo	Elementary/Seconday (0-12)	Colle	ge (1-4 or 5+	+)		NOT use retired) Housew			9	l .	Own Hor	<b>n</b> 0	
ed with	enter hyptere: Ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	Bec	17. Father's Name (First, Middle, L	4 y	rs			Housew			e (First, Middle,			iie	
Maryland 2 should be filed	rked tic ev	욘	Lonnie R.	Jorda	ın					Marga			·		
Maryl should	27 is marked o		19a. Informant's Name/Relationsh	ip (Type, Print)		191	b. Mailin	g Address (Street a	and Nun	nber or Rura	l Route Numbe	er, City or	r Town, State, Zip	Code)	
	If item 27 or other tr	l j	Carlita Davi 20a. Method of Disposition	s – da	ught			9 Dennl	yn						
mor Page 1	r = it		1 Burial 2 Cremation			cemete	ery, crem	sition (Name of natory or other plac			Date		ocation - City or	·	
Baltimore, permit. Page 1 and	Important: If i any injury or o		4 ☐ Donation 5 → Other (S 21. Signature of Funeral Service L		combmo	en#Iro	_	S Mem.  Name and Addres			14/10		alto. N		
ğ e	B m m	es d	Culles	Ita	nes		lc.	hatman-	Har	ris I	г.н. 4		altimon Relain	re, Ma r Rd 21206	
			23a. Part 1. Enter the disease, or shock, or heart failure. List o	complications nly one cause	that caused ton each line.	the death. Do	not ente	r the mode of dyin	g, such	as cardiac c	r respiratory ar	rest,		Approximate Interval Between	
7.	sician, ledical	i i	Immediate Cause (Final disease or condition resulting in death)	a. ——	SHA	oke								Onset and Death	
	aminer		resulting in death)	Du Du	ie to (or as a	consequence	of):								
988		ner	Sequentially list conditions, if any, leading to immediate	b. — Du	e to (or as a	consequence	of):								
bath	nd ransit	Examiner	cause. Enter Underlying Cause Disease or impury that initiated events	c										· · · · · · · · · · · · · · · · · · ·	
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760 cate b	physi s the t	edical		d				<u>.</u>				_			
certifi	ending use a	an/N	IF FEMALE: 23b. Was decedent pregnant		s, outcome o		th 3	Ectopic pregnanc	cv.				23d. Date of del	ivery	
Box death c	he att	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 🔲		time of death		Other (specify)					Month	Day Year	
Records, P.O. Box 68760  The law requires that the death certificate be executed	ed by t detach		Part II. Other significant condition	ns contributing	to death bu	it not resulting	in the u	nderlying cause giv	/en in Pa	art I.	23e. Did to	obacco i	use contribute to	the cause of death?	
S, F	signe Ild be	ed by	Pulmonary +	embol	(						1 🗆	Yes 2	□ No 3 □ Pr	obably 4 Dunknown	
w requ	s beer	plete	1								24a. Was			opsy findings available completion of cause of	
VItal Records, iysician: The law require:	ate ha	Completed		-	-						perfo	ormed? 2 N N	death?	2 No	
tal ician:	sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:				26. Pl		Death (Check	ì				
Phys	rthis o	5: 10	1 ☐ Yes 2 X No 27. Manner of Death	28a.	Date of injury	nt 2 ER/O y 28b.	utpatien Time of	t 3 DOA 28c. Injun	4 ⊔		me 5 A Residence 128d. Describe I		6 Other (Special Office of the Control of the Contr	(fy)	
on C anding	r: Afte	icat	1 Natural 5 ☐ Pendin 2 ☐ Accident Investig	ation	(Month, Day,	Year)	injury	work		_					
DIVISION OT tal or Attending PI rs after death.	irecto n by th	Certificate;	3 Suicide 6 Could 4 Homicide determ	28e. I	Place of Injur ouilding, etc.		arm, stre	eet, factory, office			28f. Location (S City or Tov			al Route Number,	
pital c	eral D		29a. Certifier 1 Certifying	Physician: To	the best of n	ny knowledge	death o	ccured at the time	date a	nd place, an	d due to the ca	use(s) ar	nd manner as sta	ted	
ie Hos	To the Funeral Director. After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 2 Medical E	xaminer: On th	e basis of ex	amination and/	or invest		on, death	n occurred at	the time, date a	and place	e, and due to the o	ause(s) and manner stated.	
To th	<b>10 t</b>	-	29b. Signature and title of pertifier	401				29c. License	numbe	021	17	29d, Da	ite signed (Month	Day, Year)	
			1000		2	)	-		50	0 7	/ >	M	2021	7 0 0 1 0	
•			30. Name and address of person (	vho completed	Cause of de	ath (Item 23a)	(Type, P	701 N.	W	unce	ST	D	WSUN	MO	
	Sta		31. Date filed (Month, Day, Year)		32. Registrar	's Signature				,					
	Registra	ar	AUC 1 C	1010	K.	A	1.	. al. A							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month HERYL BEVERAGE August 4:12 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Harbor Hospital Baltimore N/A Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F Days 0 494 74 1961 49 Maryland **Director** 215-74-4736 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits be notified at Director 28a-f 1 StYes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Lafayette Apt.A 1331 W. 21217 U.s.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ģ 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Black Completed 3 Divorced other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Pathology University Hospital years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Page 1 and 2 should be Frederick Eli Beverage Mamie Lee Anthony 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 i 1331 Eboni Archer(daughter) W. Lafayette Apt.A, Baltimore, MD 21217 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite any injury or oth ☐ Burial 2X Cremation 3 ☐ Removal from State 4 Denation 5 Other (Specify) 08/23/10 Baltimore, MD Signature of Funeral Service Li <sup>22</sup>Josephic Hoffabrown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ HEPATIC ENCEPHALOPATHY disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury MYOCARDIAL INFARCTION that initiated events resulting in death) Last Due to (or as a consequence of) nding physician use as the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Yes 2 M No 1 Yes 2 No the Funeral Director: After this certifical operation of the funeral director, In 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 M No 1 Yes ပ္ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Matural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Resident Res 000 2010 August 14 3001 S. Hanover Street

Registrar DHMH 17 Rev 7/2009

3altimore, Maryland 21215-0036

Box 68760

Division of Vital Records, P.O.

Harbor Hospita

Baltimore, MD 21225

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Woldesenbet

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** AME Augus 2010 /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner Baltimor N/A 21191 If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number Sex **Funeral** Months **V X**□ M 2□ F 57 214-62-7914 08/13/1952 Director Maryland Usual Residence of Decedent nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene.

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 ☐XYes 2 ☐ No **Funeral Director** N/A MD Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 3817 Boarman Ave. 21215 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🗷 No Specify Specify: Completed by 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10th Grade Laborer Book Binding Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Bell ဂ Evelyn Lewis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine Bell(wife) 3817 Boarman Ave., Baltimore, MD 21215 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Department o Important: If any injury or once. 08/13/10 | Baltimore, MD Zion Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature o Fune I Service Licens 30sephdff.offBfown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Athero scland ardiovascular Con /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (of as a consequence of) Physician/Medical Examiner burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician the for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) the 9∏Unknown 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 3 No 3 ☐ Probably 4 ☐ Unknown 05 page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has 1□ Yes 2No Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2**X** No 1 Inpatient 2 ER/Outpatient 3₽ DOA Medical Certification: To After this 27. Manner of Deal 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred or Attending 1 Natural
2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No hours after death uneral Director: 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify)28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide thin 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 alens 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 cl 31. Date filed (Month, Day, 32. Registrar's Signature Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Dennis Bruce	1- For State Registrar	State of Maryla	nd / Department <i>Certificate</i>		nd Mental H		201(	25381			
Physician Medical Examine		Middle,Last) Bruce				2. Date of Dea Month August 8,	Day Year	3. Time of Death 1435 hrs			
	4a. Facility Name (if not inst	tution, give street and num	nber)		r Location of Dea		4c. County of Dea	ath			
	1212 West Lomba		7. Ann / In comp. In all high day	Baltimore	Trett- 1 040	To Date of Di	N/A	3:41-1			
Funeral Director	5. Social Security Number 225 – 76 – 3099 220 – 76 – 3098	1 X M 2 F	7. Age (In yrs. last birthday	) If Under 1 Ye  Months Da  Yrs.		_	22,1962	eign Country) MD			
any	Usual Residence of Decede  10a, State 10b, Cou	inty	10c. City, Town or Lo			<u> </u>	-	10d. Inside City Limits			
*	MD	N/A	Baltimo	ore				1 X Yes 2 No			
the Maryland 3a or 28a-f sh otified at once		Lombard S	treet	10f. Zip Code 2122	3	1	0g. Citizen of What Co USA	ountry?			
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked offer than "natural", or items 23a or 28a-f sho injury or other tranmatic event, the Medical Examiner must be notified at once.  To Be Compulated by Firneral Director		Married 12. Was Dece Armed For 1 Yes Divorced If Yes, Give Year		Was Decedent of H If Yes, specify Cuba	n, Mexican, Puert		White, etc.	erican Indian, Black, lack			
iours a	15. Decedent's Education (Specify only highest grade completed)  during most of working life, DO NOT use retired)										
5-0036 ed within 72 hour sygiene. ofter than "natu	Elementary/Secondary (0- 9th	N/A	4 or 5+)	V/A			N/A				
1215-(d be filed tental Hyginarked oth event, the	B David Edw	ard Bruce	Taok Ma		Ethel H	H. Brow					
AD 21 2 should 1 and Me 27 is ma matic ev	Shiree Arv						nber, City or Town, Sta More,MD				
re, N I and FHealth Fitem er trau	20a. Method of Disposition	ation 3 Removal from	20b. Place of Dis	position (Name of ce	emetery,	Date	20c. Location - City				
imo Pages ment of	4 Donation 5 Other	r Specify:	Final	Journey			Woodbine	-			
Balt permit. Depart Import	21 Signatule of Funeral Ser			2700 Edm	ondson	Ave. E	· · · · · · · · · · · · · · · · · · ·	tie F/S D 21223			
Physician	23a. Irt I. Enter the disease failure. List only one ca	e, or complications that cau use on each line. Caro ase a. Athe	ised the death. Do not ent diac_Arrhyth	er the mode of dying	, such as cardiac	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death			
Examiner	Immediate Cause (Final disc or condition resulting in deat	ase a. Ather h) Due to (or as a c	onsequence of):	Cardiovas	<del>cular Di</del>	sease		Death			
-	Sequentially list conditions,	b. <b>Cardion</b> Due to (or as a c	negaly with	biventric	ılar hyp	ertrophy		-			
ted Insit Examiner	if any, leading to immediate cause. Enter Underlying Ca (Disease or injury that initiate	use ed c									
ansit	events resulting in death) Last Due to (or as a consequence of):  d.										
68760, certificate be executed inding physician and se as the burial - transit	▼ UNPENDED	7.7	<b>23a 27 per n</b> perff 6907.	18, 2906 8	-27-10 vi	t perME	G907 9/27	/2010 WS			
760, ficate be g physic the bur	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome of pregnancy				23d. Date of delive	егу			
ords, P.O. Box 6876 w requires that the death certificate is been signed by the attending phy should be detached for use as the I oleted by Physician/M	past 12 months?	I LIVE DIT	nt at time of death 5	Fetal death 3 Other (Specify)	Ectopic pregn	ancy	Month	Day Year			
P.O. I as that the gened by the detache	3	nditions contributing to d	leath but not resulting in th	e underlying cause	given in Part I.	100	obacco use contribute to	o the cause of death?			
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that th within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detach ledical Certification: To Be Completed by P.						24a. Was a autop. perfor	sy prior to med? death?				
tal R cian: T certific ector, p				26.Place	of Death (Check						
f Vit	1 ✓ Yes 2 No		patient 2 ER/Outpatie				Residence 6 🗸 Oth	er: Scene			
on on on on the first Affice function:	1 X Natural 5	28a. Date of (Month, D	Injury 28b. Time ( lay,Year)		ry at Work? Yes 2 No	28d. Describe r	now injury occurred				
Division of Spital or Attending Spital or Attending Spours after death.  Ineral Director: After filled in by the funer Certification:	2 Accident II	ovestigation 28e. Place o	of Injury - At home, farm, si	reet, factory, office t	ouilding, etc.			Rural Route Number, City			
Div spital of neral B filled i	4 Homicide	etermined (Specify)				or Town, S	tate)				
Division of Vital I  To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification by the funeral director, Completely filled in by the funeral director, Medical Certification: To Be (		g Physician: To the best of Examiner: On the basis of and manner stat	examination and/or investi	gation, in my opinior	, death occurred		and place, and due to	the cause(s)			
2	29b. Signature and title of ce	tifier		29c. Licens O.C.			29d. Date signed (M August 9, 2010	onth, Day, Year)			
	30. Name and address of per	son who completed cause	of death (Item 23a)	0.0.			, lugust 5, 2010				
	Laron Locke MD.	Assistant Medical I	Examiner 111 Pe	nn Street, Baltir	nore, MD 212	201					
State Registra	A 1 1 (7 17 17 17 17 17 17 17 17 17 17 17 17 17	ar) 32. Regi	strar's Signature								

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month AUGUST BOSTUN JACQULINE 16 :00A 0105 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE JOHN'S HOPKENS BHYVEEN MEDICAL CKNYER 8. Date of Birth (Month, Day, Year) March 5, 1940 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Min. 1 🗆 M 2🔀 F Months Hours Maryland 218-36-8990 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 28a-1 1 Yes 2 No Dundalk Maryland Baltimore 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21222 USA 40 Liberty Parkway items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. o þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give 72 hours after 2 😾 No Maryland 21215-0036 1 ☐ Yes 2 x No Specify. Specify: "natural" Completed 3√2 Widowed 4 □ Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Data Processing Data Entry Supervisor 12 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kathleen Ruff Jack C. Eggleston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2459 Fairway, Dundalk, Maryland Kathleen Onheiser Daughter Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State August 16, ò Holly Hill Memorial Grons injury Middle River, Maryland 2010 Signature of Funeral Service Licenses 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundlak, Md. 21222 23a. Part 1. Enter the disease, shock, or heart failure. or complications that caused the death. By not enter the mode of dying, such as cardiac or respiratory arrest, conly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SEPTZC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 24 hours UROSEPSTS Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) ZHIEEKS OWER UNTWARY TRACT INFECTION that initiated events Due to (or as a consequence of) resulting in death) Last burial-Physician/Medical that the death certificate be attending physical for use as the b IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, or Attending Physician: The law requires CONGESTEVE UKART Completed 2 ☐ No 3 ☐ Probably 4 ♣ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of PIARRIES 24a. Was an autopsy performe death? certificate 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 1 XYes Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 2 🗆 No 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death.

Funeral Director: After 1 🔼 Natural 5 Pending work? 1 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier 1 🖰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. The High projection in the basis of examination and/or investigation, in my opinion, death place, and due to the cause(s) and miner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 only one) 29b. Signature and title 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

EASTERN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940

32. Registrar's Signature

GIRSON

64840

BATTMORE

AVENUE

AUGUST 12, 2010

NAME KNOWN BY PHYSIEIAN: BIGGS, BIKKIE J. Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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	•	For State Registrar		Sta	te of M	arylan	•	ertificate of			•	giene Reg. No	001	0	25383
Physicia	n/	1. Decedent's Name Billie		. ,	Diago						2. Date of De		y 18	et 0	3. Time of Death
Medic Examin	al	4a. Facility Name (if			Biggs d number)			4b. City, Town	, or Location	n of Death	1 day	·			
,			YLAND	HEALTH			STEM	Milleder ( Ve	PERI	Y PO	INT		County of		
Funeral Director		5. Social Security No. 236-44-3	3097	6. Sex 1 🔀 M 2 [	☐ F 7. Ag	e (In yrs. Ia 79	ast birthday) Yrs.	If Under 1 Ye Months Day		er 24 Hrs. Min.	8. Date of Bir (Month, Da 05/22/		1	9. Birthpl Counti Wes	ace (State or Foreign Virginia
and show dat	or	Usual Residence of 10a. State	10b. County		-	10c. City	, Town or L	ocation						10	d. Inside City Limits
Maryl 28a-f otifie	Funeral Director	MD	Harf	ord		Abe	erdeer					<del></del>			1 X Yes 2 No
ith the 23a or st be r	ralD	10e. Street and Nun		un Poad	1			10f. Zip Code 2100					izen of Wha	at Count	ry?
eath w tems?	Fune	11. Marital Status	31113 1	12. Was	Decedent I	Ever in U.S	S. 13.	. Was Decedent o	f Hispanic (	Origin? (Spe	cify Yes or No-		14. Race -	America	ın Indian,
after d ", or i	þ	1 Never Marri		ried 1 🔀	ed Forces? Yes 2 s, Give	No		If Yes, specify Cu			Rican, etc.)		Cnonify:	White, e	
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should and M is ma auma		19a. Informant's Na	ame/Relations		-		19b. Mai	ling Address (Stre	et and Num	ber or Rura	l Route Numbe	er, City or	Town, Stat	e, Zip Co	ode)
and 2 Health em 27 ther to		Deloras  20a. Method of Disp		/ Wife		20b B		7 Carsin	s Run		, Aberd		MD 2 ocation - Ci		
age 1 ent of nt: If ii		1 ☐ Burial 2 d	☐ Cremation		from State	, c	emetery, cre	ematory or other p	,		1/2010			•	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fur			OS EA 4			22. Name and Add							
6 2 5 5 6		One Post 1 Establish	/m	-		10007				-			lanove		MD 21076
Physician/		Immediate Cause (	rt failure. List Final	nly ne cause	on each line	o the death		IBROSI		as cardiac c	r respiratory ar	rest,			Approximate Interval Between Onset and Death
Medical		disease or condition resulting in death)	on	a	ue to (or as			IN KOOF	J					+	Ola Mannania
Examiner	ia l	Sequentially list co	nditions,	b. —		*********								+	
ted J Insit	Examiner	cause. Enter Under Cause (Disease or	rlying iiniury		in to (or as	а повяеци	enno otr								
90 H 12		that initiated events resulting in death) t		c	ue to (or as	a consequ	ence of):								
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certific ending use as	by Physician/Medical	IF FEMALE: 23b. Was decedent		23c. If ye	s, outcome Live Birth	of pregnal	ncy	☐ Ectopic pregna	ano.				23d. Date of	of deliver	у
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hat the ed by t detach	y Ph	Part II. Other signifi		ons contributing	g to death b	out not resu	ulting in the	underlying cause	given in Pa	ırt I.	23e. Did to	obacco u	se contribu	ute to the	e cause of death?
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death ctor: A y the fi	Certificate:	2 Accident 3 Suicide	Investi 6  Could	gation not be	Place of Inio	ırv - At ho	me farm st	M 1 treet, factory, office	Yes 2			Street and	d Number o	or Bural f	Poute Number
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the but	Medical	(Check 2	Medical E	xaminer: On the	ne basis of e	xamination	and/or inve	occured at the til stigation, in my op death occurred at	inion, death	occurred at	the time, date a	and place,	and due to	the caus	se(s) and manner stated
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XV		30. <u>Na</u> me and addre	ess of person	who completed	Cause of d	eath (Item	23a) (Type,	YLAND I	HEALT	TH El	RE SYS	TEM.	PERRY	ADI	NT, MA 21901
Stat	е	31. Date filed (Month	h, Day, Year)	6 0040	32. Registra	ar's Signat		1 :	-						<del></del>

10-05969 Davon Booth Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 25384 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Davon Booth 1751 hrs **Medical Examiner** August 8, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore N/A 5. Social Security Number 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Days Hours Director 7/1/10 Country) MD 1 X M 2 F unk Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits any 10b. County MD N/A Baltimore 1 X Yes 2 No 28a-f show imore, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 5626 Woodmont Ave 10g. Citizen of What Country? USA Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 1 XNever Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) African X No 2 Yes If Yes, Give Year 1 Yes 2 No specify: Specify: American 3 Widowed 4 Divorced þ 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) N/A N/A 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Davon Letoine Booth, Sr. Lakinia S. Hundt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) မ Lakinia S. Hundt/Mother 5626 Woodmont Ave, Balt., MD 21239 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Itimore, 1 Burial 2 K Cremation 3 Removal from State Bayview Crematory 8/14/10 Balt.,MD Baltimol permit. Pages Department of Important: I 4 Donation 5 Other Specify: 22. Name and Address of Facility Hari P. 21. Signature of Funeral Service Licenses Close F.Svs, PA 5126 Belair Rd, Balt., MD 21206-5105 23a. Par 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure. List only one cause on each line /Medical Head Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the attending physician and ned for use as the burial - transit sician/Medical 23a,27,28a-f per me g914 4-12-11 vt X UNPENDED AMENDED Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Day past 12 months? Pregnant at time of death 5 Other (Specify 1 Yes 2 No 9 Unknown g Unknown signed by t I be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 至 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy this certificate has performed? death? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Hospital: 1 Inpatient 2 🗸 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other DOA 1 V Yes 2 28a. Date of Injury (Month. Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 1 Yes 2 X No within 24 hours after death. To the Funeral Director: the Pending unknown unknown subject assaulted Investigation Accident filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5626 Woodmont Ave. Apt. D Baltimore, Md. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 Could not be (Specify) 4 X Homicide apartment building 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated one) 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifles 29c. License number 29d. Date signed (Month, Day, Year) August 9, 2010 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) AUG 16 2010 32. Registrar's Signature State Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 25385 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2010 Physician/ 8:45 AM Elizabeth Bradley Martha August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Shady Grove Adventist Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Dec. 15, 1 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🂢 F Months Days Hours Min. 1919 Niota, Director 90 578-30-1299 Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Completed by Funeral Director 1 √ Yes 2 □ No Maryland Montgomery Gaithersburg 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 301 Russell Ave. Apt. 236 20877 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. 1 X Never Married 2 Married ☐ Yes 2 🛛 No 21215-0036 Specify: Black If Yes, Give 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8 U.S. Government Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Alec Bradley Mattie Hurst 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1133 Knoll Mist Ln., Gaithersburg, MD 20879 Rebecca Owens (Daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 2 Cremation 3 Removal from State 5 Other (Specify) Lanetown Cemetery 8-13-2010 Niota, Tennessee Conatio ture of F neral Service Lic 22. Name and Address of Facility
M.D. Dotson & Sons Funeral Home . Sia .0. Box 4524, Cleveland, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final neart tailure Physician disease or condition resulting in death) conastive Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) signed by the attending physician and deedetached for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant a Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No this certificate has ral director, page 2: 25. Was case referred to medical examiner? Be funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certificate: To 1 🗌 Yes 2 🔀 No 1 KInpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After injury 1 X Natural 5 Pending death. 2 Accident
3 Suicide Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined

Hospital or Attending Physician; The law requires that the death certificate be or, safter des, reral Director: A' filled in by the 24 hours a Funeral L completed To the Pwithin 2
To the P

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Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 

Certifying Number Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and Date signed (Month, Day, Year)

30 Prime and address of person who completed cause of death (Item 23a) (Type, Print)

AUG

20858 Shahryar Davan, 9901 Shady Grove Road, Rockville, MD

32. Registra 's Signature

State Registrar

Medical

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Thomas Brookh	yseı	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar  Certificate of Death Reg. No.												
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last)  2. Date of Death  Month  Day  Year												
Modiodi Exam		Thomas Edward Brookhyser August 6, 2010 1920 hrs  4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death												
		University Hospital Baltimore												
Funeral Director		5. Social Security Number 218-02-8093  1 M 2 F  7. Age (In yrs. last birthday) 43  Yrs.  1 F Under 1 Year   If Under 24Hrs.   8. Date of Birth(MM/DD/YYYY)   9. Birthplace (State or Foreign Country)												
/ any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits												
daryland 28a-f show 1 at once.	tor	MD Prince George's Bowie  10 Zip Code  1												
the Man a or 28a	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?  6702 Alexis Drive 20720 USA												
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumante event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.												
rs after ural", o	δ	3 Widowed 4 Divorced of Specify: Specify: Specify: White  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry												
6 172 hour an "nate cal Exa	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired)												
-003 I within grene. ther the	ошо	12 Heavy Crane Operator Construction  17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maiden Surname)												
215. be filed ntal Hy ked of	Be C	George Brookhyser Linda Wyatt												
21 hould ben is mar	٩	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
and 2 s lealth a tem 27 traum:	- 01	Linda Brookhyser - Mother 260 Hughart Lane, Summersville, WV 26651  20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State												
nore		1 XBurial 2 Cremation 3 Removal from State crematory or other place)												
altin mit. P partme portan		21. Signa of Funeral Se Licensee 22. Name and Address of Facility Rose & Quesenberry Funeral Home												
	.2	1901 S. Kanawha Street, Beckley, WV												
Physician //Medical		failure/List only one cause on each line.  Between Onset and												
Examiner		Approximate Interval failure/ List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Approximate Interval Between Onset and Death  Due to (or as a consequence of):												
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):												
11	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated c. Due to (or as a consequence of):												
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O, be exe sician	edica	▼ UNPENDED □ AMENDED 23a,27,28a-f per me g913 3-29-11 vt												
Box 68760, see death certificate be execut or the attending physician and hed for use as the burial - tra	<b>⋝</b> I	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)												
Box e death the atte	Physic	1 Yes 2 No 9 Unknown 9 Unknown												
	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Vulknown												
Division of Vital Records, P.O. rall or Attending Physician: The law requires that the star death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detaid	eted	24a. Was an 24b. Were autopsy findings available												
ecor ne law i te has t	ompleted	autopsy prior to completion of cause of performed? death?  1 ✓ Yes 2 No 1 ✓ Yes 2 No												
	O .	25. Was case referred to medical 26. Place of Death (Check only one)												
f Vit	70 B	examiner? 1 Yes 2 No  1 No 28a. Date of Injury  28b. Time of Injury 28c. Injury at Work?  28d. Describe how injury occurred												
on of Anding Ph.	Certification:	1 Natural 5 Pending (Month, Day, Year)												
ivisic for Atte after dea Directo	ficat	Accident  Accident  Accident  Suicide  Accident  Suicide  Accident  Could not be  Accident  Accident  Suicide  Could not be  Accident  Suicide  Accident  Suicide  Could not be  Accident  Suicide  Accident  Suicide  Could not be  Accident  Suicide  Accident  Suicide  Suicide  Suicide  Suicide  Suicide  Suicide  Suicide  Suicide  Suicide  Suicide  Suicide  Suicide  Suicide  Suicide  Suicide  Accident  Suicide  Suici												
Ospitali hours a nneral I	Cert	Suicide 6 Could not be determined (Specify) in jail cell Fac. 7311 State of Md, Correct ac. 7311 Waterloo Rd. Jessup												
Eivision of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director.	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)												
To To Io	ğ	and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)												
		Theodore Ill. First They was do O.C.M.E. OCME August 7, 2010												
0		30. Name and address of person who completed cause of death (Item 23a)  Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201												
St	ate	31. Date filed (Month, Day, Year)  32. Registrar's Signature												
Regist		AUG 1 6 2010 Brown B. Jak												
DHMH 17 Rev 1/20	001	ORIĞINAL												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 2010 Elton McCoy Bland,
4a. Facility Name (If not institution, give street and number) Bland, Sr 4c. County of Death 4b. City, Town, or Location of Death Souare Baltimore HOSpital Kosedale If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Days Hours Months 1**X** M 2□ F 12/13/1938 North Carolina 230-46-4047 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Baltimore Essex 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21221 S. A. 5 Avenal Road 12. Was Decedent Ever in U.S. Armed Forces? 1∑1Yes 2 □ No If Yes, Give Year or Dates: 196 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 M Married 1959 1 □Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced 1962 White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 Aero Space Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mizelle McCoy Bland Marie Edgar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Amanda Hazel Bland (Wife) 5 Avenal Road Essex, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ₩ Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Holly Hill Mem. Gard. Middle River, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue PA Essex, Maryland 21221 4100 as Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final DER Carbi 4 days disease or condition resulting in death) (b) as a consequence of) eudomona Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 T Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No

**Physician** /Medical Examiner

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Medical Certification: To

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**Physician** 

Examiner

**Funeral** 

Director

27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examples must be redified at

1 and 2 should be filed within 72 hours after or Health and Mental Hygiene. Sem 27 is marked other than "natural", or iter

Baltimore, Maryland 21215-0036

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or Attending Physician:

To the Hospital or Attend within 24 hours after death To the Funeral Director:

death with the

/Medical

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Completed

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-trar physician s the burial Physician/Medical

26. Place of Death (Check only one)

1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify)

2 PNo 1 □Yes

1 Yes 2 No 27. Manner of Death 1 Natural

25. Was case referred to medical

28a. Date of Injury (Month, Day, Year) 5 Pending investigation 6 ☐ Could not be determined

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA

28b. Time of

Injury

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

(Check only one)

2 Accident

4 Homicide

Warren

31. Date filed (Month, Day, Year,

3 Suicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

40

6 2010

29c. License number

28c. Injury at Work?

29d. Date signed (Month, Day, Year) 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9000 FRANKLIN 32. Registrar's Signature

1 Inpatient

MO

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Florence Evelyn Benner 2010 August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Rosedale Baltimore Manor Care Health Services Rossville 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 Maryland 6. Sex 7. Age (In yrs. last birthday) **Funeral** Aug. 27, 1930 Days 1 □ M 2 🙀 F Hours **Director** |212 28 9675 79 Usual Residence of Decedent 28a-f shov 10a. State filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified Middle River Maryland Baltimore 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g, Citizen of What Country? items 23a Funeral 2103 Redthorn Rd. 21220 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc Yes 2X No Yes, Give o, þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural" 3 X Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Day Care Baby Sitter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H f item 27 is marked ot r other traumatic ever permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve Mildred Jungblock Henry Benner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine Scanlon (Personal Rep.) 2103 Redthorn Rd. Baltimore, Maryland 21220 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory Inc. 8/13/2010 Baltimore, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A. ohn W. 1407 Old Eastern Avenue Essex. Maryland hart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, which, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ CHOLANGIO CARGINOMA disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events as the burial-transit b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Property Property: After this certificate has been signed by the attending physician and Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No page 2 should be detached for Month Year Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 🔀 Nursing Home 5 🗌 Residence 6 🗌 Other (Specify) 1 🗌 Yes 2X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

completed filled in by To the within 2

> 2 Registrar

29a. Certifie

29b

Check

only of

Parkaj Kherpol, M.D. nth, Day

Signature and title of certifier

9106 Philadelphia Rd. Suite 208 Baltimore, Maryland 21237 32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

1 🗴 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

August 12, 2010

29c. License number

D0060560

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25389 Certificate of Death Reg. N 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ James Thomas Barrett 201°0 11:37a M August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Carroll Hospice Dove House Westminster 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. July 31 1 √2 M 2 □ F 218-28-5015 78 Director 932 Usual Residence of Decedent or 28a-f shov 10b. County 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director MD Carroll Sykesville 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21784 USA 675 Johnsville Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 XYes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white "natural", 3 Divorced 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical sonce. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) electrical electrician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Thomas James Barrett Dorothy Jarboe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 675 Johnsville Rd., Sykesville, MD 21784 19a. Informant's Name/Relationship (Type, Print) Mrs. Linda Barrett (spouse) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Crest Lawn Memorial 8-17-10 Marriottsville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel . Signature of Funeral Service Licenses Pauge Haight P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final SCHEMIZ Physician/ disease or condition resulting in death) DOYS Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 2 🗆 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ous twen 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 Yes Yes 25. Was case referred tedical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital Other 욘 4 Nursing Home 5 Residence 6 Other (Specify) HOTEICE 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

DHMH 17 Rev 7/2009

State Registrar 29b. Signature and title of certifier

phu

31. Date filed (Month, Day, Year)

30. Name and address of person who complete

cause of death (Item 23a) (Type, Print)

295

32. Registrar's Signature

toner

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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral	Service bio	certsee			Name and Address Onaldson						
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completed filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2 🗂 N	ledical Ex		sis of examination	and/or invest	igation, in my opinio	on, death occurre	ed at the time, dat	e and pla	ice, and due	e to the cau	ise(s) and manner stated.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 9:34 AM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Hoso (ceneral If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug . 29 , 1 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sept **Funeral** 1 M 2 X F 243-38-9154 Director Yrs. Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director ems 23a or 28a-f sh r must be notified a 1 ☐ Yes X No MD Laurel Howard 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 10516 Twin Cedar Court 20723 USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♣ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner 0. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2XXNo "natural". Specify: white Completed 3 X Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Onesimus Craddock Lucritia Spruill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellicott City, Robert A. Bennett, Jr., Son Rusty Gate, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State August 11, 1 Burial 2 Cremation 3 Removal from State West Arundel Crem. Odenton, MD 4 Donation 5 Other (Specify) 2010 Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. Koin M01053 313 Talbott Ave., Laurel, MD 20707 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnev-Physician/ disease or condition nonia 1799 Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-trar Due to (or as a consequence of): resulting in death) Last physician Physician/Medical that the death certificate be use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? for Month Year Day Pregnant at time of death detached 9 Unknown <u>о</u>. cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, The law requires 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 2 No 1 🔲 Yes or Attending Physician; Division of Vital funeral director. 25. Was case referred to medica Be 26. Place of Death (Checklonly one) examiner? Other: 4 Nursing Home 5 Residence 6 Cther (Specify) 2 🗆 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death paccurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) elem 21044 31. Date filed (Month, Day, Year) 32. Registrar's State

DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 1 0 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Bobbutt 2010 7.50 AM Rosamond Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Regional hospital Genges M. O home el If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth Funeral 1 □ M 2 🕱 F Months (Month, Day, June 30 Year Country) Virginia Director 101 215-36-5313 Usual Residence of Decedent or 28a-f show 10a, State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 ☐ Yes 2 🗓 No Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 11901 Wimbleton Street 20774 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or ģ 1 Never Married 2 Married 72 hours after 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Specify: White Completed Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Assistant 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Robbins (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Mary Ann Rogers / Daughter 11901 Wimbleton Street, Upper Marlboro, MD 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date injury or 1 KBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 8/16/2010 Brentwood, MD Fort Lincoln Cem. 22. Name and Address of Facility Donaldson Funeral Home, 21. Signature of Funeral Service Licensee M00770 313 Talbott Avenue, Laurel, MD 20707 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician/ movel disease or condition Medical resulting in death) Examiner poxemia. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed per ten sur Due to dr as a consequence of): resulting in death) Last Physician/Medical p mules a the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death n signed by the a Id be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autonsy performed? Yes 2 No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 1 No Other: 1 Yes မှ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined To the Hospital of within 24 hours a To the Funeral D Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State

Karunni

ideden

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kazman

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

Lamel

8-13-2010

M. D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 25393 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ <sup>□</sup>型,201°0 Adqust 3:03A Charles Anthony Bregier Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Harford Forest Hill 1623 Louanne Court, Apt. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** June 14 Days Min. 1932 Michigan 362-32-4481 78 Director Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director X Yes 2 ☐ No Oakland Bloomfield Hills Michigaþ 10e, Street and Number ō 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 48304 U.S.A. 2360 Hunt Club Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or \$ 1 Never Married 2 X Married 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) and Mental Hygiene. Automobile Finance 18. Mother's Name (First, Middle, Maiden Surname) UNK Be 17. Father's Name (First, Middle, Last) ၉ John Bregier Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21050 permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Andrea Bregier Louanne Court, Apt. C, Forest Hill, Maryland 1623 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date van Hoosen Ones Cemetery XBurial 2 Cremation 3 Removal from State 8-7-10 RochesterHills, Mi. 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P. A mulace 6009Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Jon-small disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Exami that the death certificate be executed nding physician and use as the burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No ò Month Day Year the. 1 Yes 2 L 9 Unknown P.0. ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? ₽ Records, 3 Probably 4 ☐ Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate ☐ Yes 2 X No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director. After this certifica completed filled in by the funeral director: r 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work' 1 Yes 2 No ☐ Accident ☐ Sulcide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one Charles Rd. MOPED 29b. Signature DO061040 Person who completed cause of death (Item 23a) (Type, Priht)

Registrar DHMH 17 Rev 7/2009 30. Name and address of

Box 68760

Division of Vital

32. Registrar's Signa

23a) (Type, Prifit) 1550 Ocleans St, Rus 44

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) August **Physician** Sharlene Noma Burrhus /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince George's Regional Hospita Laurel If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2X F Director 220-32-5199 Maryland Sept.17,1936 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County ernit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan op-riment of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f showing injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland PrinceGeorge's Laurel Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 9001 Cherry Hill Lane 20708 Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: White <u></u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Elizabeth Trageser Albert Charles Burrhus 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 709Denver Avenue, Chesapeake, Virginia 23322 Sherry L. Rahuba/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State ArdentCremation, Inc. 8-16-10 | Hanover, Maryland 4 ☐ Donation 15 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. Muchael Programmes 6009Harford Road, Baltimo 6009Harford Road, Baltimo 23a. Part1. Enter the disease, or corp rications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 6009Harford Road, Baltimore, Maryland21214 Immediate Cause (Final disease or condition resulting in death) Septic **Physician** /Medical Due to (or as a consequence of) **Examiner** Aspiration neumonia Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine the death certificate be executed sician and burial-tran Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. ☐Yes 2☐No ate has been signed by the page 2 should be detached 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ⋧ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ▼No 24a. Was an autopsy perform certificate 2 No completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို 1 🗌 Yes 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending F within 24 hours after death.
To the Funeral Director; After Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier (Xcrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

Registrar

31. Date filed (Month, Day,

Road,

Van Dusen

30. Name and address of Person who completed cause of death (Item 23a) (Type, Print)

Year)

7300

2. Registrar's Signature

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death 3. Time of Deg Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Seasons Hospice e Northwest Hospita andallstown Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Min. Country) 216.92.2456 1 - M 2 X MD Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director Glen Burnie Avunde 1 - Yes 2 10 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21060 Street Oak Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forceş? 14. Race - American Indian Black, White, etc. "natural", or 1 Never Married 2 Married 1 Yes 2 No Completed by Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Day Care Provider and Mental Hygiene. Self Employed Britars Page 1 and 2 should be filed nent of Health and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Evel Bradle Terome F. Brown, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i other tra Street and Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Department of I 1 Burial 2 Cremation 3 Removal from State injury or Moodlann 4 ☐ Donation 5 ☐ Other (Specify) Woodlawa emetery permit. Greene Funeral SUCS 21. Signature of Funeral Service Licenses any adallstown 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine Use to for selection evolution evoluif any, leading to immediate cause. Enter Underlying burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be exe attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) ☐ Pregnant at time of death☐ Unknown signed by the a d be detached f 9 Unknow Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed? death? After this certificate 2 [] No Be 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) examiner? Hospital Other: 잍 ER/Outpatient 3 DOA 1 Inpatient 2 I 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 Natural injury 5 Pending fter death. 2 No Investigation Accident the 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of pro knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Augu 8:45 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE LOCHEARN 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F 82 Months Days Hours Min. (Month, Day, Year) Director 52-40-1004 seorgia Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Nes 2 □ No Mary land 10e. Street and Number Baltimore ò 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 5516 ELDERUN U.S.A. 21215 Avenue items ; hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. ò 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: BLACK "natural", 3 
Widowed 4 Divorced Completed 15. Decedent's Education 16b. Kind of Business Industry
DRESS SHOP 16a. Decedent's Usual Occupation CDRess (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Meagnes, once. Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed eamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 ARthur MADISON FOR MAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 FRED CLARK-AUE, BALTIMORE, MARYLAND HUSBAND Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) BALTIMORE, MARYLAND 2010 Signature of Funeral Service 22. Name and Address of Facility The DERRICK C. JONES FIH, P.A. PARK HIGHS, AUE. , BALTIMORE, 23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each line e death. Do not enter the mode of dying, such as codiac or respiratory arrest Approximate Interval Betwe et and Death Immediate Cause (Final Physician/ eroscleroti disease or condition Medical resulting in death) Dy to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of): burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician the burial Physician/Medical Box 68760 as attending IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown be detached 9 Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 ☐ Yes 2 ☐ No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Natural work? 5 Pending injury Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatu License numbe 29d. Date igned (Month, Day, Year) 05 2010 address of person who completed cause of death (Item 23a) (Type, Print)

WWW.TT 7835 SH (7H A MITTINGKT 31. Date filed (Month State Registrar

Shelred (AKA Shelton) Lee Carr 10-06043 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 2010 25397 1- For State Certificate of Death Registrar Reg. No Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death Medical Examiner SHELRED (AKA SHELTON) August 12, 2010 0202 hrs LEE CARR 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3418 Garrison Boulevard Baltimore 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Director Months Davs Hours 2\_\_\_F 08-12-1953 Country) NC 57 <u> 217-66-7130</u> Usual Residence of Deceden any 10b. County 10c. City. Town or Location 10d. Inside City Limits or items 23a or 28a-f show must be notified at once. 1X Yes 2 No hours after death with the Maryland BALTIMORE Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3418 GARRISON BLVD 21215 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? 1 X Never Married 2 Married White, etc. 1 X Yes 3 Widowed 4 Divorced If Yes, Give Year Yes 2 X No specify: Specify: BLACK ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) filed within 72 the Medical 21215-0036 12 MAINTENANCE APT. Pages 1 and 2 should be filed within nent of Health and Mental Hygiene, ant: If item 27 is marked other th Com 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be traumatic event, LEWIS RUBY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RUBY CARR/MOTHER <u>3710 BELLE AVENUE.</u> BALTO. MD 21215 20a. Method of Disposition 20b. Place of Disposition (Nam Baltimore, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State crematory or other place) Department o 4 Donation 5 Other Specify GARRISON FOREST 08-23-10 OWINGS MILLS, MD 21 Signature of Funeral Service Licenses 22. Name and Address of Facility JAMES A. MORTON & SONS F.H. 9 1701 LAURENS ST., BALTO., MD 21217 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear **Physician** Approximate Interval failure. List only one cause on each line. /Medical Between Onset and a. Gunshot Wounds of Head Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that immated events resulting in death) Last Due to (or as a consequence of) and transit law requires that the death certificate be executed Physician/Medical UNPENDED attending physician or use as the burial -AMENDED Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy 1 Live birth past 12 months? Month Day Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? page Yes 2 1 Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi 25. Was case referred to medical director 26.Place of Death (Check only one) æ Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other Scene 2 ER/Outpatient 3 DOA 1 ✔ Yes 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification Aug 12, 2010 Division 1 Natural Subject shot 0153 hrs 5 Pending 1 Yes 2 ✔ No the 2 \_\_\_ Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Suicide 6 Could not be or Town, State) 3418 Garrison Boulevard , Baltimore , MD (Specify) Front Steps 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c, License number 29d. Date signed (Month, Day, Year) O.C.M.E August 12, 2010 nd address of person who completed cause of death (Item 23a)

5+1

OCMF 2006

DHMH 17 Rev 1/2001

State Registrar

OCME

6

Assistant Medical Examiner

32. Registrar's Signature

Laron Locke MD.

31. Date filed (Month, Day, Year,

**ORIGINAL** 

111 Penn Street, Baltimore, MD 21201

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

AUG 1620

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 20**T**O Dolores Helen Cannon 4:35 P. ™ August Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Baltimore Timonium Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth May 12, 1934 If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🗓 F Months Days 213-32-0322 Maryland Yrs. Director 76 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified Maryland N/A1 X Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 111 Hamlet Hill Road Unit 1008 21210 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 ☐ Never Married 2 🎇 Married 1 ☐ Yes 2 X No If Yes, Give Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2121 Elementary/Seconday (0-12) College (1-4 or 5+) Law years Secretary Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Anthony Debinski Helen Switalski Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21210 Leroy L. Cannon (husband) Hamlet Hill Road Unit 1008 Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ō 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Garrison Forest Veterans Cem. 8-23-10 Owings Mills, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Road Baltimore, Maryland 23a. Part 1. Soler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 21212 shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ CEREBROVASCULAR ACCIDENT Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 Yes 2 No 3 Probably 4 M Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work Division 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

no

ERNESTINE WRIGHT, MD

31. Date filed (Month, Day, AUG 1620

ress of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signal

D.E

AUGUST

DOLORES

2300 DULANEY VALLEY RD.

6

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Marylar	•			nd Men	tal Hyg	jiene						
			1 - State Registrar	Cer	tificate of L	Death		R	leg. No2 ()	10	25400				
PI	hysicia	ın/	1. Decedent's Name (First, Middle, Last)  C-EO rgia Cunning ham					Date of Deat Month	, Day	Year	3. Time of Death				
_	Medic		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	r I apption of I	Dooth	Augu.	,, , , ,	2010	12:10 PM				
-	Examin	ier	601 Cherrycrest Road Apt	В	Baltin		Deam		4c. County	of Death					
Fu	uneral		5. Social Security Number 6. Sex 7. Age (In yrs. I		If Under 1 Year	If Under 24		ate of Birth			place (State or Foreign				
Dír	rector		250-24-6640 1XM2 F 96	Yrs.	Months Days	Hours	Min. (	Month, Day, 3-25-	Year) <b>-1914</b>	Cour	S.C.				
pu	how at	=	Usual Residence of Decedent           10a. State         10b. County         10c. Cit	y, Town or Lo	cation					$-\tau$	10d. Inside City Limits				
lanyla	3a-f s tified	Director	MD na Ba	altimo	ore						1 🎇 Yes 2 □ No				
the M	or 2		10e. Street and Number		10f. Zip Code			1	10g. Citizen of	What Cou	ntry?				
<b>21215-0036</b> within 72 hours after death with the Maryland giene.	ns 23a	Funeral	601 Cherrycrest Road Apt 1	3	2122	25			US	Α					
death	r iter		11. Marital Status  12. Was Decedent Ever in U.  Armed Forces?		Vas Decedent of H f Yes, specify Cuba	ispanic Origin an, Mexican, F	n? (Specify Y Puerto Ricar	es or No- , etc.)		ce - Americ ck, White,	can Indian,				
)36 after	al", o Exam	Completed by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	1	☐ Yes 2X No	Specify:			Specify		Black				
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d with	ther t	Be C	8th grade na		omestic		_		Priva		Homes				
land be filed ental Hyg	ed o	To E	17. Father's Name (First, Middle, Last) George Lyons			18. Mother's	· _	t, Middle, N ark	faiden Surnam	ə)					
Maryland 21215-0036 2 should be filed within 72 hours after the and Mental Hygiene.	item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print)	19h Mailin	g Address (Street a				City or Town S	State Zin	Code)				
e, Maand 2 st Health a	ı 27 is ər traı		Booker T. Henderson-Son	1	-						1D 21225				
of He	fiter roth	ļ.	20a. Method of Disposition 20b. F	Place of Dispo	sition (Name of natory or other place	į	Date		20c. Location -						
Page '	tant; jury o		4 Donation 5 Other (Specify)	relan	d Memor	ial8-	-17-2	010	Parkv	$ill\epsilon$	e, MD				
Baltimore, permit. Page 1 and Department of Hea	Important; If i any injury or o once.	ľ	Signature of Fune Service Licensee 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202												
	_ (0 0)	- 70	23a. Part 1. Enter the disease, or complications that caused the deat	h Do not ente						o,ME					
Db o	ioion/		shock, or heart failure. List only one cause on each line.			-		•	51,		Approximate Interval Between Onset and Death				
	ician/ edical	ñ	Immediate Gause (Final disease or condition resulting in death)  Atheros during a. Due to (or as a consequence)		craiovasc	ular	Diseq	SE		-					
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77	æ	Examiner	if they, leading to immediate cause. Enter Underlying	lence of:											
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Box 68760 death certificate be executed	ohysician and the burial-transit	dical	Tooliting in octain) East	301100 01).											
760 icate b	g phys	ledi	d						-	土					
certifica	e asn	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 posths2  1 ☐ Live Birth 2 ☐ Fets		Ectopic pregnanc				23d. Da	te of delive	ery				
<b>Box</b>	s been signed by the attending p should be detached for use as t	Physician/Me	in the past 12 months?  1   Yes 2   No 9   Unknown    Unknown		Other (specify)	, y			Mo	nth	D <i>a</i> y Year				
that the	etach	Phy	Part II. Other significant conditions contributing to death but not res	ulting in the u	nderlying cause giv	ven in Part I		220 Did tob	anco uno contr	ributo to tl	ne cause of death?				
S, P.C	signe d be c	d by	<del>.</del>		,g g						bably 4 Unknown				
cords,	shoul	lete					_	24a. Was ar			psy findings available				
Hec The law	s certificate has a lirector, page 2 s	Completed						autops perforn	ned?	death?	mpletion of cause of				
2 T	tor, p		25. Was case referred to medical examiner?		26. Pla	ace of Death (		1 ☐ Yes 2 one)	2 L No	1 🗌 Yes	2 LJ No				
VIT hysic	nis ce	욘	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3 🗆 DOA Othe	er: 4 🗆 Nursi	sing Home 5	Reside	nce 6 🗆 Othe	er (Specify	)				
Ing P	funera	Certificate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work	?	[	Describe hov	w injury occurre	∍d					
SIO	y the 1	tific	2 Accident Investigation 3 Suicide 6 Could not be	me farm etre		Yes 2 ☐ No	-	anation /Str	not and Numbe	or Or Puro	Route Number,				
Division of Vital Records, tal or Attending Physician: The law requires is after death.	d in b		4 ☐ Homicide determined 206. Place of injury - At no building, etc. (Specify		ot, ractory, office			ity or Town,		n or nurar	noute Number,				
Division of Vital To the Hospital or Attending Physician: Within 24 hours after death.	unera ed fille	Medical	29a. Certifier 1 Certifying Physician: To the best of my know	edge, death o	ccured at the time,	date and pla	ace, and due	to the caus	e(s) and manne	er as state	ed.				
the H hin 24	me ri		(Check 2 ☐ Medical Examiner: On the basis of examination only one) 3 ☐ Certifying Nurse Practioner: To the best of m	knowledge, d	eath occurred at the	e time, date <i>a</i> n	nd place, and	due to the	cause(s) and ma	nner as st	ated.				
P with	<u>9</u> 8		29b. Signature and title of certifier		29c. License	number 0057	465	29	9d. Date signed	(Month, I	Day, Year)				
			30. Name and address of parent who completed source of death //learn	23a) (Tupo D	rint)		0 1				- :: (**)				
31	/		29b. Signature and title of certifier  MSNAMPUMNM. 0  30. Name and address of person who completed cause of death (Item  N. S. RUMPOKSE, M.D. 2835	Smill	nAV S-	203,	Balt	mor	e, MI	1. 21	1209.				
	Stat	е	31. Date filed (Month, Day, Year) 32. Registrer's Signal		-72										
Re	egistra	ır	AUC 1 6 2010	A	hace &										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Physician/ Month 1925 6 Medical 4a. Facility Name (if not institution, give street and numb or Location of Death **Examiner** 4b. City, Town 4c. County of Death Balt more n: Wers: mor Birthplace (State or Foreign Country)
 M Social Security Number If Under 24 Hrs. If Under 1 Year 7. Age (In vrs. last birthday) 8. Date of Birth Funeral (Month, Day, 05 - 28 -1 🔀 M 2 🗆 F Days Months Min. 75 220-30-5721 MD **Director** Usual Residence of Decedent shov 10a. State items 23a or 28a-f sho her must be notified at 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** MD NA Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 607 Pennsylvania Avenue Apt. 21201 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. African 6 à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes, Give 1 Tes 2 XNo Specify: Specify: American "natural" Completed 3 XWidowed 4 □ Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) A.M.E. Zion Elementary/Seconday (0-12) College (1-4 or 5+) 8th Grade Custodian Baptist Church ΝA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ should be Garland Crawford, Sr. Violet Gamble 19a. Informant's Name/Relationship (Type, Print) #405 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 strent of Health a tant: If item 27 i Rose White-Friend 607 Pennsylvania Avenue Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗌 Burial 2 🖾 Cremation 3 🗍 Removal from State 08-13-10 Catonsville, MD Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licenses 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or compline nons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only on ause on each line Immediate Cause (Final **Onset and Death** Physician/ OSIS disease or condition resulting in death) Medical Dup to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the al d be detached for Part II. Other significant conditions contributing to cath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 🗷 Probably 4 ☐ Unknown Completed page 2 should peen Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed. Yes 2 death? certificate 1 ☐ Yes 2 🔀 No within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: ည 1 🔀 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 1 X Natural 5 Pending 1 Yes 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 1396063521 w un 10 225, GREENE SI BALTIMORE, NO and address of person who completed cause of death (Item 23a) (Type, Print) CENTER MALYLAND

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Dav. Year)

Tavon Cadwell Unk Unk

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 2010 25402 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar			Certifica	ate of	Death			Re	eg. No.			
Physiciai Medical Examin	1/	1. Decedent's Name (First, Midd $Tavon$		$1$ dw $\epsilon$	11			·	- 1	2. Date of Deal Month August 8,	Dav	Year		3. Time of Death 1515 hrs
		4a. Facility Name (if not institution  Johns Hopkins Hospi	on, give street and n			4	b. City, Town, o Baltimore	r Location	of Death		4c.	County or	Death NA	
Funeral Director		5. Social Security Number 219-06-4882	6. Sex	7. Age (I	n yrs. last birt 25	hday) Yrs.	If Under 1 Yes		er 24Hrs. Min.	8. Date of Bir 09 <b>–</b> 2			9. Birth	nplace (State or number) MD
any		Usual Residence of Decedent  10a. State 10b. County		10	c. City, Town	or Location	on	. 1 .						10d. Inside City Limits
Aaryland 28a-f show 1.at.once.	įį	MD 10e. Street and Number	NA		Balti	mor	E 10f. Zip Code				0a Citiz	en of Wha	at Coun	1XX Yes 2 No
the Mau	Director	4015 Edgev	wood Str	eet			212	<b>1</b> 5				USA	_	
er deat	Funeral	11. Marital Status  1XX Never Married 2 M  3 Widowed 4 Div	larried 12. Was De Armed F 1 Yes vorced If Yes, Give Ye	orces?		If Ye	Decedent of Hi es, specify Cuba	ın, Mexican				White,	etc.	an Indian, Black, African cican
7 3 1	Completed by	15. Decedent's Education (Spe Elementary/Secondary (0-12)	ocify only highest gra			Decedent during mo	's Usual Occupa st of working life	ation (Give			16b. K	ind of Bus	iness/Ir	
MD 21215-0036 12 should be filed within 72 th and Mental Hygiene. 77 is marked other than " unafte even, the Medical	E S	8th Grade 17. Father's Name (First, Middle	, Last)			Car	pentry	18.Mother	's Name (	First, Middle, N		mpar Surname)	ıу	
21215-00: and be filed with Mental Hygiene marked other t	8	Ronald  19a. Informant's Name/Relations	Anthon	y B	rown	Mailing	Address (Stro	Wan		Lynet				Zip Code
ore, MD 21 ss 1 and 2 should of Health and Mes If iten 27 is man	-1	Petite Green	,		4	6 S	olar C	ircl	e Ap	t."D"	Ва	ltin	ore	e, MD
ages 1 and 2 and 2 to of Health t: If item 2		20a. Method of Disposition  1 X Burial 2 Cremation		rom State	cremate	ory or oth	tion (Name of ce er place) n • Pk •	emetery,		14-10			-	rown, State
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other ti	ł	4 Donation 5 Other S			11116	22. Na	ame and Addres		Wy	lie F	une	ral	Ног	ne P.A.
Physician	+	23a. Part I. Enter the disease, of failure, List only one cause		aused the	death. Do no					treet respiratory arre				Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Marking Co.											Death
	اي	Sequentially list conditions, if any, leading to immediate	b										_	
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760,  Toate be executed physician and the burial - transi	Medical	IF FEMALE:	23c. If yes,	outcome (	of pregnancy						23d	. Date of c	elivery	
688 certif se as	ysician	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Uni		nant at tim	e of death 5	$\equiv$	al death 3 er (Specify)	Ectopio	pregnano	Су	'	Month	Di	ay Year
P.O. B es that the de igned by the de detached i	≥	Part II. Other significant condit	tions contributing t	o death bu	it not resulting	in the ur	nderlying cause	given in Pa	art I.			se contrib		ne cause of death?
cords, Plaw requires that been sign 2 should be control of the con	Completed	-								24a. Was a				opsy findings available ompletion of cause of
tal Recc										perfor			ath? ✓ Yes	2 No
of Vital Recing Physician: The After this certificate funeral director, page	lo Be	25. Was case referred to medica examiner?  1 ✓ Yes 2 No	11 2 1	Inpatient	2 🗸 ER/Ou	itpatient		Other4	-	Home 5	Resider	nce 6	Other:	
Division of Vital Records, as for a trending Physician: The law requirers after death.  al Director: After this certificate has been significant has been significant has been significant has been significant.		27. Manner of Death  1 Natural 5 Pend 2 Accident Inve	ding stigation	of Injury Day Year) 2010	28b. 1 1456	ime of In		ury at Work Yes 2 ✔	. Is	8d. Describe h ubject shot		ry occurre	d	
Division pital or Attene ours after death reral Director: filled in by the	Certification:	3 Suicide 6 Coul	ld not be 28e. Plac	e of Injury		rm, street	, factory, office	building, et		8f. Location (S or Town, S 300 Germani	tate)			al Route Number, City MD
	<u>न्</u>	29a. Certifier 1 Certifying P	hysician: To the be miner:On the basis and manner:	of examin	nowledge, dea ation and/or ir	th occurr	ed at the time, d	late and pla n, death oc	ace, and di	ue to the cause the time, date a	e(s) and and plac	I manner a ce, and du	s state	d cause(s)
	Ĭ	29b. Signature and title of certifie	Pro1	) ,			29c. Licens O.C.	se number .M.E.	•			ate signe ust 9, 20		th, Day, Year)
1 ^	ł	30. Name and address of person Patricia Aronica-Polla	· ·		h (Item 23a) lical Exam	iner	111 Penn S	treet Ro	ltimore	MD 21201	1			
Sta		31. Date filed (Month, Day, Year)		gistar's						2120				
Registro DHMH 17 Rev 1/200	_	AUG 1.6	2010	HIGH.	OP OP	GINAL	No.		<del></del>					-
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OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Alice cumy Magust 9:30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Northwest Seasons Randallstown Hospice If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 04-05-28 1 M 2 F 212-26-6642 82 Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director XX Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or the Medical Examiner must be Funeral 3713 Beehler Avenue 21215 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, White, et Trican 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) þ 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: American 3 XWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Cashier Hardware Fair 10th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filk Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ဂ္ Robert Wiggins Ida Wiggins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2121519a. Informant's Name/Relationship (Type, Print) Ethel Janet Gale-Daughter 3713 Beehler Avenue Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State Woodlawn Cem. 08-19-10 Woodlawn, MD 4 Donation 5 Other (Specify) Wylie Funeral Home P.A. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) LUNG Cancer Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): ng physician and as the burial-transit that the death certificate be executed Cause (Disease or iiniury that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No ō Day Year Pregnant at time of death led by the a detached f Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ should be To the Hospital or Attending Physician: The law requires twithin 24 hours after death.
To the Funeral Director: After this certificate has been sign 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Dother (Specify) 1 Inpatient 2 ER/Outpatient 3 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

M5KMMMMM

O 29d. Date signed (Month, Day, Year) D0057465 8/12/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) \_ S - 203 - Balthmore, MD: 21209.

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Box 68760

P.O.

Division of Vital

32. Registrer's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25404 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Peter John DiLutis 5-15 AM 3 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimose FRANKLIN Square Hospital Center Rosedal 8. Date of Birth (Month, Day, Year) November 24,1926 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Hours Country Pennsylvania 83 Director 214-22-3987 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Balto. Nottingham 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 306 Elinor Avenue 21236 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Ty Yes 2 □ No
If Yes, Give 1944–1946
Year or Dates. Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 X Widowed 4 ☐ Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Communications Technician T&TA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ John DiLutis Julia Mallica 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa McDaniel DTR. 804 Delray Court Forest Hill, Md. 21050 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State Gardens of Faith 8-13-2010 Balto. Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Schimunek Funeral Home 22. Name and Address of Facility 9705 Belair Road Nottingham, Md.21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ TOXIC Encephalopathy disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Renal Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury DIFFICILL C OLITIS Clostridium that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be cardiomyopath Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 L 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed death? within 24 hours after death.

To the Funeral Director. After this certificate is completed filled in by the funeral director, pag. 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical e e 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ျှ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier Wolfantil 1069193 AUGUST, 11, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 FRANKLIN SQUARE DR Balto md 21237 DR JOHN KO KoTTaraThiL

DHMH 17 Rev 7/2009

State

Registrar

AUG 1 6 201

. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2 Date of Death . Decedent's Name (First, Middle, Last) **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 09/08/1921 5. Social Security Number . Age (In yrs. last birthday) **Funeral** Days 1 M 2 X F 88 221 24 0400 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. 10a. State 10c. City, Town or Location items 23a or 28a-f show must be notified at Director MD Anne Arundel Pasadena 10f. Zip-Code 10e. Street and Number 21122 8411 Echo Drive Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examiner. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 X Yes 2 ☐ No Specify: Puerto Rican þ 3 ¥ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)

Be

17. Father's Name (First, Middle, Last)

**Physician** /Medical **Examiner** 

page

or Attending Physician: The law requires that the death certificate be executed completely filled in by

Division of Vital Records, P.O. Box 68760,

P E	Ernesto Qui	nones			Jo	seph	ine	Samb	olin	
_	19a. Informant's Name/Relationship (Ty	rpe. Print)	19b. Ma	iling Address	(Street and Numb	ber or Rural	Route Numb	er, City or	Town, State, Z.	ip Code)
	Stephen T. Dav:	is - Son	841	1 Ech	no Dr.	Pasa	dena	, MD	2112	22
	20a. Method of Disposition		20b. Place of Dis	position (Nan ematory or of	ne of	Dat	te	20c. Loca	ation - City or	Town, State
	1 ☐ Burial 2 🛣 Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify)		, ,		matory	8/13	/10	Bal	timore	e, MD
	21. Signature of Funeral Service License	ee			d Address of Facil Riviera	. 63	Gonce	Fun	eral a, MD	Home, PA 2 <b>11</b> 22
	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	lications that caused the cause on each line.	e death. Do not e						,	Approximate Interval Between
	Immediate Cause (Final disease or condition	a. Stro								Onset and Death
	resulting in death)	Duè to (or as a	consequence of):							
niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	bDue to (or as a	consequence of):			•				
al Exar	that initiated events resulting in death) Last	cDue to (or as a o	consequence of):							
edica		d			, ,		· · · · · ·			
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₹ No 9 □ Unknown	23c. If yes, outcome of 1  Live birth 2  4  Pregnant at tir 9  Unknown	Fetal death	B				23	3d. Date of deli Month	ivery Day Year
d by Ph	Part II. Other significant conditions co	entributing to death but	not resulting in the	e underlying	cause given in Par	rt I.	23e. Did			o the cause of death?
omplete							24a. Was auto perfo 1  Yes		24b. Were au prior to death?	itopsy findings available completion of cause of
Be C	25. Was case referred to medical				- 26. Plac	e of Death (	Check only o	ne)		
o B	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 XInpatient	2 ER/Outpati	ent 3 DC	Other: 4 🗆 N	lursing Home	5 🗆 Resi	dence 6	Other (Spec	cify)
	27. Manner of Death  1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Y	28b. Time Injur		8c. Injury at Work? 1 ☐ Yes 2 ☐		d. Describe	how inju <b>ry</b>	occurred	
edical Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury building, etc.	- At home, farm, s (Specify)	street, factory	, office	28	Bf. Location City or To		Number or Ru	ural Route Number,
dical C	29a. Certifier 1 Certifying Phy (check only one)	vsician: To the best of r iner: On the basis of e and manner state	xamination and/or	ath occurred investigation	at the time, date a , in my opinion, de	and place, ar eath occurre	nd due to the	e cause(s) a , date and	and manner as place, and du	s stated. e to the cause(s)
Me	29b. Signature and title of certifier			290	. License number			29d. Date	signed (Month	h, Day, Year)

Medical Technologist

25405

3. Time of Death

210

Birthplace (State or Foreign Country)

Puerto Rico

10d. Inside City Limits

1 ☐ Yes 2 X No

Reg. No.

ZO Year

4c. County of Death

10g. Citizen of What Country?

Specify:

600 North Wolfe St, Baltimore, MD, 21287

18. Mother's Name (First, Middle, Maiden Surname)

16b. Kind of Business/Industry

U.S.A.

14. Race - American Indian,

White

University Hospital

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen J. Hudd (Eston

Registrar's Signature

31. Date filed (Month, Day, Year)

AUG 1 6 201

RESODO

			For State Registrar		State o	of Mary		•	tment of l ificate of			ental Hy	giene Reg. N	010	254	06
		_	Decedent's Name (Fi	irst, Middle, Las	t)							2. Date of De	-	010	3. Time of	
	Physicia /Medic		Joe Cassel	1 Ellio	tt							Month August	11,	2010 Year		РМ
	Examin		4a. Facility Name (If no			ımber)		4	lb. City, Town,		n of Death			County of Dea		
a del <sup>e</sup>			Kline Hosp						Mount					rederi		
	Funeral Director		5. Social Security Numb		ex MIM 2□ F	7. Age (In	yrs. last birth		If Under 1 Year Months Days		Min.	B. Date of Bir (Month, Di Sept.	rth ay, <i>Year)</i> 15 <b>,</b> 1	939 Vi	rthplace (State of Country) rginia	r Foreign
	nd ×		Usual Residence of Dec	cedent b. County		100	c. City, Town	or Loon	tion						10d. Inside Ci	by Limite
	f sho	or		Erederic	16	100		rmo							1 □ Yes	
	the 1	rect	10e. Street and Number		. K		1110		10f. Zip Code				10g. Citiz	en of What C	country?	
	h with	Funeral Directo	7195 Brown	s Lane					217	788			Uni	ted St	ates	
	deat	iner	11. Marital Status		12. Was Dec		in U.S.	13. Wa	s Decedent of es, specify Cub	Hispanic C	Origin? (Spec	ify Yes or No	0- 1	4. Race - Am Black, Wh	nerican Indian,	
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "scient Evaral he malth of anone.	Ď	1 ☐ Never Married 3 ☐ Widowed 4 ☐		1 XXYes If Yes, G Year or □	2 ☐ No ive			os, spesily cal ]Yes 2 <b>⊠</b> No			iouri, oto.)		Specify: W		
5-0036	72 hou natura dical E	Completed	15.	Decedent's Ed	ucation de completed)		1 1	(Give kir	nt's Usual Occu	durina mo	ost of working	7	16b. Kir	d of Busines	s/Industry	
127	within ene. than "	du	Elementary/Secondar		College (			life. DC	NOT use retire ty Offi	ed)		,	Fed	eral G	overnmer	ı t
7	filed v Hygie ther t	ပိ	17. Father's Name (Firs				56	curi	Ly OILI		her's Name (	First, Middle			OVETHING	
Maryland	ld be ental ked o	To Be	Archie Ell								na Rob					
<u>چ</u>	shou ind M imar	-	19a. Informant's Name		ype. Print)		19b.	Mailing	Address (Stree				per, City or	Town, State,	Zip Code)	
	alth a alth a 2 27 is		Margaret B	. Ellio	tt / W:	ife	719	95 B	rowns I	Lane,	Thurm	ont, N	۵D 21	788		
or c	es 1 a of He f Item r oth		20a. Method of Disposit		Dame of frame	2	0b. Place of l	Disposit	ion (Name of tory or other pla	ace)	Aug. Da	ig.	20c. Loc	cation - City o	r Town, State	
Ĕ	. Pag tment tant: I jury o		4 □ Donation 5 □	Other (Specify	)	State	Memo	rial	Garder	ıs ¦	20	10			, Maryla	ınd
Baltimore,	permit Depar Impor any in once,		21. Signature of Funera	al Service Licen	see	м	01237								dy P.A. k, MD 21	701
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~v.	Physician		Immediate Cause (Final disease or condition			Den	nen.	f 13	0						Onset and I	Death
	/Medical Examiner		resulting in death)		Due to	(or as a cor	nsequence of	f):								
	Lamine	2	Sequentially list condition if any, leading to immediate	ions,	b. Due to	(or as a cor	nsequence of	n·								
	uted J Insit	Examiner	Cause (Disease or initial	rv	Bac to	(0) 43 4 00	nacquerioc o	.,.								
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õ	ertific ing p		IF FEMALE:													
ž Q	atth co	ian/	23b. Was decedent pre in the past 12 mor			birth 2 🗌	Fetal death		Ectopic pregnan	псу			2	3d. Date of d Month		/ear
j	y the d	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	0	9 Unk	nant at time	e or death	5 🗆 (	Other (specify)							
.v.	s that ined b e deta	by Pt	Part II. Other significar	nt conditions o	ontributing to o	leath but no	t resulting in	the und	erlying cause g	iven in Par	t I.	23e. Did	tobacco us	se contribute	to the cause of d	eath?
ecords	en sig											1 🗆	Yes 2	] No 3 🕍	Probably 4 🗆 l	Jnknown
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<u> </u>	ate h	Com										perfe 1 □Yes	ormed? 2 Z No	death	s 2 No	
vital	ician: Sertific ector,	Be	25. Was case referred to examiner?	to medical	Llegaitel						ce of Death	(Check only	one)	·		
5	Phys	.T	1 ☐ Yes 2 A No 27. Manner of Death		Hospital: 1 ☐ 28a. Date		2 ER/Out		3 🗆 DOA			e 5 Res		Other (Sp	pecify) HOSP	æ
SION	ding h. After fune	tion		Pending investigation	(Mor	nth, Day, Yea		jury	28c. Inju Wo M 1	ork? □Yes 2[		a. Describe	now injury	occurred		
2	Atter r deal ector: by the	ifica	3 ☐ Suicide 6	Could not be	28e. Place	e of Injury	At home, fari	m, stree	t, factory, office		_	Bf. Location	(Street and	d Number or i	Rural Route Num	ber,
5	tal or rs afte al Dir	Certification:	4 Homicide		Duild	ling, etc. (S	pecny)					City or 10	wn, State)			
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death, within 24 hours after death, to the Funeral Director. After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as sometimes of the completely filled in by the funeral director, page 2 should be detached for use as some page 2.	Medical	29a. Certifier (Check only one)	Certifying Ph Medical Exam	iner: On the	e best of my pasis of exa nner stated.	y knowledge, amination and	death of	occurred at the stigation, in my	time, date opinion, d	and place, a leath occurre	nd due to the d at the time	e cause(s) , date and	and manner place, and de	as stated. ue to the cause(s	)
	To th Vithir To th	Me	29b. Signature and title	ocertifier	2 1				29c Licer	nse numbe	-100	/	29d. Date	e signed (Ma	nth, Day, Year)	
•	inx\		30. Name and address	of person who	completed cau	se of death	(Item 23a) (	Type, Pr	int)	00	10	<i>T</i>	0	0:5	2010	
	V		31. Date filed (Month,	Ody. Tear)	5/6	Registratos	Rignature F	tvo	e re	ed	eric	C	MD	21	102	
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10-05949 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Manchil Farley State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death Month Day August 8, 2010 0310 hrs Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death NIA 2518 West Lanvale Street Baltimore 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Davs Hours Director Country) 1 X M Yrs Usual Residence of Decedent 10b. County any 10a State 10c. City. Town or Location 10d. Inside City Limits s 23a or 28a-f show e notified at once. 1 Yes 2 No more, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10e. Street and Number 10g. Citizen of What Country Funeral 12. Was Decedent Ever in U.S 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. Never Married 2 2 X No Yes 4 Divorced If Yes, Give Year 1 Yes 2 No specify: the Medical Examiner ۵ 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life, DO NOT use retired) nt of Health and Mental Hygiene.

It: If item 27 is marked other the other trannatic event, the Medi 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname Be ဂ္ 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, 19an Informant's Name/Relationship (Type, Print) PAR 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 1 Burial 2 Cremation 3 crematory or other place) Removal from State Donation 5 Other Specify 5 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory Approximate Interva Physician failure. List only one cause on each line Between Onset and /Medical a Smoke Inhalation Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Oisease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and - trans Physician/Medical UNPENDED AMENDED attending physician or use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy 1 Live birth Fetal death Month Day Year 2 past 12 months? Pregnant at time of death Other (Specify, 1 Yes 2 No 9 Unknown should be detached for Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy After this certificate has performed death? page 2 Yes 2 ✔ No Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi 26.Place of Death (Check only one) 25. Was case referred to medical Be Other<sub>4</sub> Inpatient ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other, Scene 1 V Yes 28a. Date of Injury (Month Day Year) Aug 8, 2010 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Victim of a housefire Natural 1 Yes 2 ✔ No Pending the 2 🗸 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f, Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) 2518 West Lanvale Street, Baltimore, Md (Specify) Townhouse / Rowhouse Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 8, 2010 Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 11, 2010 7:00 P M Frank Francis Favazza, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Lorien Health Care Center Baltimore Timonium Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral Maryland 1 X M 2 🗆 F Days october 6. 217-24-1846 82 Director Usual Residence of Decedent or 28a-f show 10c. City, Town or Location 10a. State 10h County 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at Director 1 Tes 2 X No Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 12240 Roundwood Road #510 21093 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner. Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc Completed by 1 Never Married 2XXMarried Maryland 21215-0036 1 ☐ Yes 2x No Specify. 3 ☐ Widowed 4 ☐ Divorced Specify: White WW II Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) General Contractor/Developer Construction Be ( 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Frank Francis Favazza, Sr. Biagia Azzara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Emma E. Favazza (Spouse) 12240 Roundwood Road # 510 Timonium, Maryland 21093 timore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Entorpment Dulaney Valley Cem. Maus. 8/16/2010 Timonium Maryland 21. Signature of Funeral S 22. Name and Address of Facility 21204 Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md. 23a. Part . Inter the disease, or shock, or heart failure. List only omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final End PARKINSON's Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): To the Hours of a Matending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and graphered life in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by ivision of Vital Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29h. Sionatule and title of certifier 29d, Date signed (Month, Day, Year) D CRNP RO79544 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

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31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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Physician (Medical Examiner)  22   Part I, first the disease, or complications that of used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure, list only one cause on each ine.  23   Part I, first the disease, or complications that of used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure, list only one cause on each ine.  24   Part II, class (Final disease)  25   Cause (Final disease)  26   Cause (Final disease)  26   Cause (Final disease)  27   Cause (Final disease)  28   Part II, class (Final disease)  29   Part II, class (Final disease)  20   Cause (Final disease)  20   Cause (Final disease)  20   Cause (Final disease)  21   Cause (Final disease)  22   Cause (Final disease)  23   Cause (Final disease)  24   Cause (Final disease)  25   Cause (Final disease)  26   Cause (Final disease)  27   Cause (Final disease)  28   Cause (Final disease)  29   Cause (Final disease)  20   Cause (Final disease)  21   Cause (Final disease)  22   Cause (Final disease)  23   Cause (Final disease)  24   Cause (Final disease)  25   Cause (Final disease)  26   Cause (Final disease)  27   Cause (Final disease)  28   Cause (Final disease)  29   Cause (Final disease)  20   Cause (Final disease)  20   Cause (Final disease)  20   Cause (Final disease)  20   Cause (Final disease)  21   Cause (Final disease)  22   Cause (Final disease)  23   Cause (Final disease)  24   Cause (Final disease)  25   Cause (Final disease)  26   Cause (Final disease)  27   Cause (Final disease)  28   Cause (Final disease)  29   Cause (Final disease)  29   Cause (Final disease)  20   Cause (Fin	Itim it. Pagurtment portant:	ŀ				Mead								
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29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  O.C.M.E.  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a)  Jack Titus MD. Deputy Chief Medical Examiner  111 Penn Street, Baltimore, MD 21201  31. Date filed (Month, Day, Year)  32. Registrar's Signature	P.O. es that igned be deta	≥		oonanda	ing to death	rodinoricod	iting in the c	inderlying ca	use give	arini Parti.				
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			For State Registrar	State of Mary		artment of H		nd Mental Hyg	giene Reg. No 1	0 25410	n
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Karen Ann		F	roli		2. Date of Dea Month Quaist	Day 10 2	3. Time of Death Year Ο ΙΟ ΙΟ 15 Ρ	
	Examir		4a. Facility Name (If not institution, give str The Johns Hopkins Hos			4b. City, Town, or <b>Baltimore</b>		Death J	4c. County of	f Death	
	Funeral Director		215-82-51/8		n yrs. last birthday) 2 Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Birtl Min. (Month, Day 4-6-19	v, Year)	Birthplace (State or Foreig Country)     MD	gn
	f show	or	Usual Residence of Decedent	10	Oc. City, Town or Loc		minste	er		10d. Inside City Limi	
	with the Na or 28a- be notified	Director	10e. Street and Number 445 Sawgrass	C+		10f. Zip-Code	21158		10g. Citizen of Wh	nat Country?	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral		!. Was Decedent Ever Armed Forces? 1 ☐ Yes 2X No	r in U.S. 13. V			? (Specify Yes or No- luerto Rican, etc.)	14. Race -	- American Indian, , White, etc.	
-0036	e hours aff utural", or eal Examii	by	3 Widowed 4 Divorced  15. Decedent's Educ:	If Yes, Give Year or Dates:	16a. Deced	Yes 2X No			Specify: 1	white	14
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Mary	nd 2 shoualth and M 27 is mai		19a. Informant's Name/Relationship (Types Kathy Robinson-s					or Rural Route Number Westminst	-		
Baltimore,	Pages 1 all ent of Hezent: If item		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Rei 4 ☐ Donation 5 ☐ Other (Specify)	noval from State		atory or other place		Date 8/14/10 V	20c. Location - Ci		
Baltii	permit. P Departm Importar any injur		21. Signature of Funeral Service Licensee	Elikhi -	22.	Name and Address	ss of Facility	Fletcher t.,Westm:	r Funer	al Home	
(R.,)	Observations		23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final	cause on each line.	death. Do not ente	r the mode of dying	g, such as ca	rdiac or respiratory ar		Approximate Interval Between Onset and Death	
	Physicían /Medícal Examiner		disease or condition resulting in death)	Due to (or as a co	onsequence of):	ariuloc	YFIC	Sarcoma			-
	rted Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	pue to for as a co	эпаециеное он.		•				_
,097	death certificate be executed e attending physician and ed for use as the burial-transit	dical Exa	that initiated events c. resulting in death) Last	Due to (or as a co	onsequence of):						
9	.o. o. o.	Φ.	IF FEMALE: 23b. Was decedent pregnant 23c	. If yes, outcome of p	regnancy				23d. Date	of delivery	$\exists$
P.O. Box	the death / the atter ached for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 Live birth 2 4 Pregnant at time 9 Unknown		Ectopic pregnancy Other (specify)			Month		
GS, P.	v requires that the death certif been signed by the attending should be detached for use a	by	Part II. Other significant conditions contr	buting to death but n	ot resulting in the ur	nderlying cause giv	en in Part I.	23e. Did to		oute to the cause of death?	vn
e G		Completed			,			24a. Was a autops perform	sy prie	ere autopsy findings availab ior to completion of cause o eath?	
		Be C	25. Was case referred to medical examiner?	spital:		Otho		Death (Check only on	ne)	Yes 2 No	_
0	this ald	ion: To	27. Manuer of Death 1 Natural 5 Pending	1 Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatient 28b. Time of Injury	28c. Injury Work	at ?	28d. Describe h	ence 6 Other		_
JIVISION	he rat	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - building, etc. (S			∕es 2 □ No	28f. Location (S City or Town		r or Rural Route Number,	7
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by t	Medical Ce	29a. Certifier (check only one) 1 Certifying Physic 2 ☐ Medical Examine	ian: To the best of my r: On the basis of exa and manner stated	mination and/or inve	occurred at the timestigation, in my op	e, date and pointion, death of	place, and due to the o	cause(s) and mani date and place, ar	ner as stated. nd due to the cause(s)	
	To the within To the comple	Mec	29b. Signature and title of certifier			29c. License			29d. Date signed (/		
	lov		30. Name and address of person who com	USK FLO			5 00	0	08-	-11-2010	$\dashv$
	Sta	e.	31. Date filed (Month, Day, Year)	encia McZ			60	00 North Wo	fe St, Balt	imore, MD, 2128	37
	Registra	_	AUG 1 6 20:	D Marchen		10.00					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 7:45 AM 2010 0 9 /Medical 4a. Facility Name (If not institution, give street and number. 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HAVEN NURSING HOME CATONSVILLE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Mar. | 3, Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral West Virginia 1 □ M 2 ⋤ F Months 83 236-34-3178 Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examination to an existing an annual conce. Director Maryland Baltimore 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 524 N. Charles St. by Funeral 21201 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🕱 No Specify: White Specify. 3 □XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Server Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Grover Bowen ဂ Bessie G. Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrew Flury (Son) 3501 Davenport Ct., Apt. J., Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 8/16/10 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service License 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final **Physician** Advance disease or condition resulting in death) /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner SCV and Due to (or as a consequence of): Box 68760, attending physician law requires that the death certificate be Physician/Medical the as ase 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Pregnant at time of death 5 Other (specify) P.O. the detached 9 I Unknown 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 2 No 1 ☐Yes 2 ☐No 1 □ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 🖃 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi Certification: 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1- Natural 5 Pending To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 □Yes 2 □ No 2 Accident investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ca 29a, Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

21

State Registrar N'Entone

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

82

MD

AHMED

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 8 Year ZO/ orna Medical 4a. Facility Name (if not institution **Examiner** 4c. County of Death ot If Under 1 Year . Age (In yrs. If Under 24 Hrs 8. Date of Birth 9. Birthplace (State of Foreign **Funeral** Country) ENGIAND 1 M 2 X F Days Months Hours Min. **Director** -90-2637 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene.
r is marked other than "natural", or items 23a or 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD BALTIMORE 10e. Street and Number 10g. Citizen of What Country? Funeral 21244 ENGLAND 16 MOUNTAIN GREEN Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married δ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates. Specify: BLACK 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HEALTH CARE MANAGER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 212 44 permit. Page 1 and 2 shu Department of Health an Important: If item 27 is any injury or other trau once. 16 MOUNTAINGREEN CR. BALTIMOR 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 08 2010 BALTIMORE, MARY IAND CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility A & DERRICK C. JONES FILL, P. A. ture of Funeral Service Lice BALTIMORE, MARVIAN e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final ∜nysician/ disease or condition resulting in death) acre Communicating Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) eral Director: After thi filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5  $\square$  Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I Medical 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check

State Registrar only one)

31. Date filed (Month, Day, AUG 1 6 2010

who completed cause of death (Item 23a) (Type, Print)

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month THAM Seyah 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death toward œ Columbia Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 - M 2 - F 12-19-1928 248-56-4284 81 Director NC Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ▼ Yes 2 No BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4009 WOODRIDGE RD. 21229 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tyes 2 No Specify: If Yes, Give Year or Dates Specify: BLACK Completed 3 

Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) FEDERAL GOVT. CUSTODIAN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည WILLIAM BELLAMY ELLA **STEVENSON** H. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANCES BLYTHER/DAUGHTER 3832 PALMETTO CT., ELLICOTT CITY, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State GARRISON FOREST 08-18-10 OWINGS MILLS, MD 4 Donation 5 Other (Specify) 21. Sigrature of Funeral Service Licenses 22. Name and Address of Facility JAMES A. MORTON & SONS F.H. ame 1701 LAURENS ST., BALTO., MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) that the death certificate be exe physician Physician/Medical IF FEMALE: 23b. Was decedent pregnant yes, outcome of pregnancy 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ Live Birth 2 Fetal death
Pregnant at time of death in the past 12 months? for Month 1 Yes 2 Unknown detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by the Hospital or Attending Physician; The law requires 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page 2 autopsy performed 2 No 1 Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28h Time of 28d. Describe how injury occurred 1. Natural 5 Pending work' 24 hours after death. Funeral Director: A 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one 29b. Signat∳re and title of cer 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Box 68760

P.O.

Records,

Division of Vital

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 920 Philip James Gordon AM 8 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Rosedale If Under 1 Year | If Under 24 Hrs. Baltimore FRANKLIN SQUAVE HOSPITal Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Min. Months Hours 1 XM 2□ F 016-40-5321 93 Yrs April 30, 1917 Haiti Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits Baltimore Perry Hall 1 ☐ Yes 2 No 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 8701 Silverhall Road 21128 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐Yes 2X No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Glopak Inc Mechanical Engineer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eugenie Oriel Robert H. Gordon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8701 Silverhall Road, Perry Hall, MD 21128 Mirianne Gordon/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill Memorial Garder 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) August 14, Middle River, MD 2010 Gardens 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremetion Services 8800 Harford Rd. Parkville, MD 21234 23a. Parth. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Failure epsis Due to (or as a consequence of) COLITIS DIFFICITE lostridium Due to (or as a consequence of):

Physician /Medical Examiner

use as the burial-transi

signed by the attending physician and dbe detached for use as the burial-tran

page 2 should

After this certificate has funeral director, page 2 s

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Completed by

Be

Certification: To

Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

**Physician** 

/Medical

**Examiner** 

10a. State

MD

Director

Completed by Funeral

Be

၉

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantice must be notified at once.

Gった人のハードトトリー Baltimore, Maryland 21215-0036

Sequentially list conditions, if any could be cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 9 🗆 Unknown

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown

5 ☐ Other (specify)

3 Ectopic pregnancy

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Lymphoma

24a. Was an

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

autopsy performed' 2 No 1 □ Yes

24b. Were autopsy findings available prior to completion of cause of death? 2 □ No

25. Was case referred to medical examiner?						26. Place of Dea	th (C	heck only one)	
1 Yes 2 Mo	Hospital: 1 Impatient	2 🗆 ER	Outpatient/	3 🗆 D	Oth Oth	er: 4 ☐ Nursing H	lome	5 Residence	6 ☐ Other (Specify)
27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Injury (Month, Day, )		b. Time of Injury		28c. Injui Wor			. Describe how inj	

27 investigation 2 ☐ Accident 3 ☐ Suicide

6 ☐ Could not be determined

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

4 Momicide

29a. Certifie

29c. License number DOO 69296 29d. Date signed (Month, Day, Year) 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4000 FRANKLIN Sac ace DR Palto md B. Gangalam 31. Date filed (Month, Day, Year)

State Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 062010 Thomas Patrick Golden August 10:30 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 8603 Wintergreen Court Apt. 306 0denton 9. Birthplace (State or Foreign Country)
New York If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 1 X M 2 □ F Days Hours 05-08-1928 Director 82 074-22-7621 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No. MDAnne Arundel 0denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8603 Wintergreen Court Apt. 306 21113 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married 1 X Yes If Yes, Give Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: and Mental Hygiene.

is marked other than "natural", 3 Divorced 4 Divorced Year or Dates White permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 0wner Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Beatrice Brady Thomas Golden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yolanda V. Golden / Wife 8603 Wintergreen Court Apt. 306 Odenton, MD 21113 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 
Burial 2 Cremation 3 
Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 08-12-2010 Valhalla, New York Kensico Cemetery 21. Signaly e f Juneral Service Livense 22 Name and Address of Facility Donaldson Funeral Home & Crematory, P.A Annapolis Road Odenton, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ theroscherosi disease or condition Medical resulting in death) to (or as a ownsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): sician and burial-transit Exami Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be Box 68760 phys the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? 2 No signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by undifficiency, Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Fibrilation, prosta 1 ☐ Yes 2 ☐ No 1 🗌 Yes Hospital or Attending Physician: Be Was case referred to medical examiner? **Division of Vital** 26. Place of Death (Check only one) funeral director 1 Yes 2 No Hospital: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 A Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work? 2 No Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the firms, date and closes, as did with the firms. re and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0067751

State Registrar

DHMH 17 Rev 7/2009

CLOUGHUN

8601 Veterans Highway, Suite 111

Millersville, Maryland 21108

and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Cinclair Griggs August 10°, 9:10 AM 20°1°0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 1813 Old Eastern Avenue Essex 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 XM 2 A Months Days Hours Min. Lousiana Dec 26, 1924 439-38-6594 85 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Md. Baltimore City 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 344 Imla Street 21224 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?
1 ☑ Yes 2 ☐ No ģ 1 Never Married 2 Married X Yes Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) 12th Painter General Motors yrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ John Glandfield Griggs Cora Anais La Cour 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
344 Imla Street Baltimore, Maryland 21224 19a. Informant's Name/Relationship (Type, Print) Clara V. Griggs (wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State August 1X Burial 2 Cremation 3 Removal from State 14,2010 Baltimore, Maryland Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilit Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee 1201 Dundalk Avenue Baltimore. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause o Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Schemic Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
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To the Funeral Director: After this certifica completed filled in by the funeral director, it of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Assisted Living

6X Other (Specify) Other: 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending Division 1 ☐ Yes 2 ☐ No Acciden
Suicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29d, Date signed (Month, Day, Year) DOOG August 12, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 21224 Eastun 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

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Funeral Director		213-20-	1	□M 2 <b>⊠</b> F	86		Months Days	s Hours Min.	8. Date of Bir (Month, Da 06/23	y, Year)	4 Viro	ntry) ninia
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r 28g	Director	10e. Street and Nu	<u> </u>				10f. Zip Code			10g. Citize	n of What Cour	ntry?
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2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, It is Medical Evan it we must be a vilified a			ame/Relationship (					et and Number or Ri				
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Physician		Immediate Cause disease or condition	(Final	ATHI RE	Sik	EROT	IL COT	REBROVA	CUHAR	. D	IS EASE	Onset and Death
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The law requires that the death certificate are has been signed by the attending phys bage 2 should be detached for use as the law are as the law are as the law are as the law are as the law are as the law are as the law are as the law are as the law are as the law are as the law are as the law are as the law are are as the law are are as the law are are are as the law are are are are are are are are are are	þ	Part II. Other sight	SDiLA O-	contributing to death	Jul Hot 1 <del>e</del> 5i	ultilig ill tille u	ilderlying cause (	giveiriii raiti.		Yes 2□		
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To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral dir	ca	29a. Certifier (Check only		hysician: To the bes miner: On the basis	of examina							
the I hin 2 the I	Medical	one)	1 111 - 4	and manner s	tated.	<del></del>	20a Liaa	ense number		20d Date	signed (Month	Day Vear)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AUGUST 13 2010 5:15 pM Charles A. Hall, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON 8. Date of Birth (Month, Day, March 11. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours Min 1 X M 2 🗆 F Baltimore, MD Director 215-18-0616 March Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director Examiner must be notified MD **Baltimore** Lutherville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? tems 23a Funeral 1015 Adcock Road 21093 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, .0. þ 1 Never Married 2 Married Yes, Give 2 No 72 hours after Specify: White 1 Yes 2 No Specify: "natural", Year or Dates. WWII 3 X Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 4 Social Security Admin. **Auditor** Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1015 Adcock Road, Lutherville, MD 21093 Kenneth S. Hall/ son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Gardens 08/18/2010 Timonium, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Towson, MD 21204 Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause of each line Immediate Cause (Final Ph, sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequuse as the burial-trans and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ō Month Dav 5 Other (specify) Pregnant at time of death detached g Unknown 9 Unknown en signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificale has autopsy eb d Hospital or Attending Physician: T e 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 21 No 1 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Investigation Accident within 24 hours after death

To the Funeral Director:

completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29d, Date signed (Month, Day, Year) drive Suti 201 Towlor se of death (Item 23a) (Type, Frint) 7101 Osh 0017 U Registrar's Signature 32. State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year Arthur 505 PM 2010 A-Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Howard County General Hospital Prince George Columbia If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number Age (In yrs. last birthday) 8. Date of Birth Funeral (Month, Day, eb 16, 1 X M 2 D F Days Hours Min. 77 **Director** Tennessee 579-40-6170 Feb ī′933 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Prince George Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 6411 Park Hall Drive 20707 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces?
1 X Yes 2 □ No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. Specify: 3 Divorced 4 Divorced White Year or Dates. 1953-55 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Accountant Hotel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Dean Alexander Hillev Grace Howell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alexis C. Hilley / spouse 6411 Park Hall Drive, Laurel, Maryland 20707 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 4 Dongtion 5 Other (Specify) Gate of Heaven Cem Aug 12, 10 Silver Spring, MD Signature of Funeral Service Licensee 22 Name and Address of Facility Donaldson Funeral Home, 313 Talbott Ave. Laurel, P.A. M00773 Maryland 20707-4389 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) / Neum onia Medical Due to (or as a consequence of) **Examiner** Inall Non Cancer Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed as the bunial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Dav Year Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pulmonar. 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy perform 2 1 No 1 Yes 2 4No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 1 No I ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Natural 1 Yes 2 🗌 No Accident Investigation Funeral Director: 3 Suicide 4 Homicide Could not be in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

within 7 State

the

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Registrar

29a. Certifier

3

29b. Signature and title of certifier

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

00066515

29d. Date signed (Month. Day, Year)

10710 Charter Dr., Suite 310, Columbia, MD

07

2010

29c. License number

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			FOF	partment of Health and N ertificate of Death	∕lental Hygid Reg	2010	25420						
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death						
	/Medic	cal	John P. Henry  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Aug 7, 201	4c. County of Deat	3:00 A M						
	Examin	ier	118 Arundel Beach Rd	Severna Park		Anne Arund							
	Funeral Director		5. Social Security Number  131 -14 - 2485  6. Sex  131 - 14 - 2485  7. Age (In yrs. last birthday 1	Months Days Hours Min	8. Date of Birth (Month, Day, ) Oct 21, 19	rear) Co	thplace (State or Foreign ountry) NY						
	and ww		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits						
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	th the	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Co	ountry?						
	s 23a	ral	118 Arundel Beach Rd	21146		USA							
δ 5	within 72 hours after death with the Maryland jien. I than "natural", or items 23a or 28a-f show the Mydeal Eva , item met ben offited at	by Funeral	1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2√☐ No	<ol> <li>Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto</li> <li>1 ☐ Yes X No Specify:</li> </ol>	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.						
5-0036	hours tural"		3 ☐ Widowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education 16a. De	cedent's Usual Occupation	16	Sb. Kind of Business/							
515	nin 72 9. an "na Modic	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	ive kind of work done during most of work	king	b. Tana or Basiness	y						
7	e filed within 7 al Hygiene. I <b>other than "</b> r vent, tre ver	Con		est		Arch Diocese							
yland	be file	Ba	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma	iiden Surname)							
Š	should nd Me mark matic	၉	John J. Henry  19a. Informant's Name/Relationship (Type. Print)  19b. Ma	Margare ailing Address (Street and Number or Rui	et Foley ral Route Number. (	City or Town, State.	Zio Code)						
Mar	alth an 27 is 27 is er trau			Oakland Hills Dr., Arno									
ore,	es 1 and 2 should be filed voll Health and Mental Hygin of Health and marked other fitem 27 is marked other rother traumatic event, tr					c. Location - City or	Town, State						
Бапптог	E Pag tment tant: f		4□Donation 5□Other (Specify) Sacred H	leart Cemetery   Aug 13	, 2010 Cu	utchogue, NY							
ра	permit. Pages 1 and Department of Healt Important: If item 2 any Injury or other once.		21. Signature of Fyneral Service Licensee  K. Gregory Fink  M01148	22. Name and Address of Facility Fink Funeral Home, P.A 426 Crain Hwy S., Glen		21061							
			23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.			it,	Approximate Interval Between Onset and Death						
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	VE HEART FA	tillike								
	Examiner		Due to (or is a consequence of):										
	D #	ner	if any leading to immediate Due to (or as a consequence of):	IN NOTA CONSCIO	111								
١.	ecuted and transif	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):										
2/2007	eath certificate be executed attending physician and for use as the burial-transit	ai E)	resulting in death) Last Due to (or as a consequence of):										
20	ifficate g phys as the	edical	d										
X O D	th cert tendin r use a	an/M	IF FEMALE: 23b. Was decedent pregnant in the part 12 months?  1 □ Live birth 2 □ Fetal death	3 ☐ Ectopic pregnancy		23d. Date of de							
	the dea / the at ched fo	Physician/M		5 Other (specify)		Month	Day Year						
Л	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours attendeath.  Within 24 hours attendeath.  Where the Funeral Birector: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit.	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	. /	o the cause of death?						
ecords,	v requ been should	etec	ALT-HOLMERS		24a. Was an		utopsy findings available						
Ž	The lav te has age 2	Completed	ALDI(E(MCE-)		autopsy performe	prior to death?	completion of cause of						
VII a	ian: ] ertifica stor, p	Be C	25. Was case referred to medical examiner?	26. Place of Dear	1 ☐ Yes 2 th (Check only one)	1	s Z LINO						
5	ding Physician: The h. h. After this certificate h. funeral director, page	은	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa		ome 5 Residen	7	75515/ED						
SION	ding F h. After funer	tion:	27. Manner of Deat 28a. Date of Injury 28b. Time 1 Natural 5 □ Pending (Month, Day, Year) 1 Natural 1 Natural 1 Natural 1 Natural 2 □ Accident Investigation		28d. Describe how	injury occurred							
	Attence er death ector: by the	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm,		28f. Location (Stre	et and Number or R	ural Route Number,						
5	talor rs afte al Diru led in l	Cert	4 ☐ Homicide determined building, etc. (Specify)		City or Town,	State)							
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one) (Check only one) (Check only one)	r investigation, in my opinion, death occur	rred at the time, dat	te and place, and due	e to the cause(s)						
	vithin To th	Me	29b. Signature and title of certifie	29c. License number	296	d. Date signed (Mon	th, Day, Year)						
			· White M	D D27157	A	ugust 8	, 20/0						
	5		30. Name and address of person who completed cause of death (Item 23a) (Typ. Ray Not. b) DEFESTRE 3100 Log: 31. Date filed (Month, Day, Year) AUG 16 2010  32. Registrar's Signature	e, Print)	dua As	10.	MAD 712.10.						
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	PACITMORE 1/K	#IJU 1/4	MORE	My rust						
	Registr		AUG 1 6 2010										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 0 1 0 Year Auq 8:25A Beulah Marie 9 Harry Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Carroll Westminster 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X Hours (Month, Day, Year) 3 / 1 6 / 1 9 3 4 Country)
MD **Director** 216-30-2804 76 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director MD Carroll Westminster 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 102 Timber Ridge Dr., Apt. 21157 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Armed Forces?

1 Yes 2 No Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exal Specify.White 3 ☐ Widowed 4 ☑ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Cleaning Presser Be 18. Mother's Name (First, Middle, Maiden Surname)
Edith Loretta Shamer 17. Father's Name (First, Middle, Last) Herman Wesley Cullison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Eyler-niece 5027 Babylon Dr., Taneytown, MD 21787 20a, Method of Disposition 20b. Place of Disposition (Name of Date 1 🔲 Burial 2 🔀 Cremation 3 🗔 Removal from State south Carroll Crem 8/10/10 Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fletcher Funeral Home 21. Signature of Lineral Şervice Linensee homes 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Lheumabid Atromai CS Ph, sician/ disease or condition resulting in death) OUCAR Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Univerlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Yea Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed þ 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an within 24 hours after death.

To the Funeral Director, After this certificate has I autopsy Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 🗆 Nursing Home 5 🗆 Residence 6 🖫 Other (Specify) DOソビ いんじょ 2 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA apleted filled in by the funeral 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 Yes 2 No ☐ Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Daţe signed (Month, Day, Year) 12010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) エリソ Tus Avenue WESTMINSTER STOWER 31. Date filed (Mont State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 01:34 PM Augus Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE TOWSON CENTER JOSEPH MEDICAL 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) **Funeral** Months Days Hours Min. Country) 4-065 Yrs. **Director** Usual Residence of Decedent 28a-f shov 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 💢 No 10f. Zip Code 212/1 10e. Street and Number 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 Tho
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industr (Give kind of work done during most of working ife. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be Maryland 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, ၉ luhnsa 19a. Informant's Name/Relationship (Type Town, State, Zip Code, rriend or other Baltimore, 20b. Place of Disposition (Name of Cemetery crematory or other 20a, Method of Disposition permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signatura of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ EMBOLISM PULMONARY burs disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence oi) Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Year Pregnant at time of death 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by ENSION 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, . Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital 1  $\square$  Yes Certificate: To ER/Outpatient 3 DOA 4 Nursing Home 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After Natural Accident (Month, Day, Year) iniun 5 Pending 2 🗌 No M 1 Yes Investigation filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital within 24 hours To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D0047638

State Registrar

7601 OSLER DRIVE

TOWSON MARYLAND 21204

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M.D.

32. Registrar's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4.

31. Date filed (Month, Day, Year) AUG 1 6 2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Jerscheid 2010 10:30 AM Elizabeth August 4 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 2610 Canterbury Road Parkville Baltimore 8. Date of Birth (Month, Day, Yea 9/19/1931 9. Birthplace (State or Foreign Country) Maryland Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 □ M 2 X F Days Hours Director 213-28-2932 78 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Examiner must be notified at Director 1 Yes 2 No Baltimore Maryland Parkville ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2610 Canterbury Road 21234 items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Yes 2 No
If Yes, Give
Year or Dates. "natural", or 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. 3 X Widowed 4 □ Divorced Specify: Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Men Elementary/Seconday (0-12) College (1-4 or 5+) 8 Cashier Grocery Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Wrightson Elizabeth Evelvn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Gaunch (Daughter) Canterbury Road Parkville, Marvland 21234 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 2617 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Mem; Gard Overlea, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician 010 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events quence of) that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy Live Birth 2 - Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 month Month Year Pregnant at time of death signed by the a d be detached f g Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 2 No 3 ☐ Probably 4 ☐ Unknown cate has been sig page 2 should b Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No certificate 1 Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4  $\square$  Nursing Home 5 XResidence 6  $\square$  Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accident 5 Pending work' 2 🗌 No death. 1 Yes within 24 hours after death

To the Funeral Director: A
completed filled in by the f Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of confifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 25424 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Ethel Jordan August 7:30A.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 2503 Violet Avenue Baltimore Social Security Number If Under 1 Year If Under 24 Hrs
Months Days Hours Min. 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday Funeral Days 1 M 2 XF Months NorthCarolina **Director** 114-24-7855 76 June 4 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director X Yes 2 □ No Maryland Baltimore 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? Funeral 2503 Violet Avenue 21215 S.A 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. "natural", or 1 Never Married 2 Married þ 1 Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ▼No Specify. Specify: Completed 3 

Widowed 4 □ Divorced Black the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Housekeeper other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) UNK 17. Father's Name (First, Middle, Last) n and Mental H James Dunn Artina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Derartment of Health ar Important: If item 27 is any injury or other trau once. Clinton H. Jordan/Son 3302 Aurora Lane, Apt6, Baltimore, Maryland21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cremation, inc. 8-10-10 Hanover, Maryland Ardent Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility Marzullo Funeral Chapel, P. A 6009Harford Road, Baltimore, Maryland 21214 michael margulk 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Coronary Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Stage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hypertension Cause (Disease or iinjury that initiated events resulting in death) Last burial-transi Due to (or as a consequence of) physician s the burial Physician/Medical requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown sate has been signage 2 should to Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? 1 ☐ Yes 2 ☐ No 2 1 No \_ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: ျ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural . vatural ☐ Accident ☐ Suic injury work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death.

To the Funeral Director; Ai
completed filled in by the fu Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, gearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) RES-000 , M.D. August 10,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 601 North Caroline Street, Baltimore, MD 21287 Estebes Hernandez M.D. 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 10 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ernest Causey Kiehne August 13 9:45 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 800 A-Southerly Road Apt # 1024 Baltimore Towson 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 X M 2 D F 5/12/1918 Mary and 218-10-7435 Director Usual Residence of Decedent 10b. County with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f sl other traumatic event, the Medical Examiner must be notified i Mary land Baltimore Towson 1 Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? by Funeral 800 A-Southerly Road Apt # 1024 21286 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 X Married 1 Yes 2 X No Specify: Specify: White 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mutual Fund Manager Legg Mason Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Louis August Kiehne Eva Causey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy W. Kiehne / Wife 800 A-Southerly Road Apt # 1024 Towson, Maryland 21286 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 
Burial 2 
Cremation 3 
Removal from State Hilltop Serv. Corp 8/17/2010 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Sudden Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 N 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death.

Funeral Director: After this certifica 25. Was case referred to medical To Be 26. Place of Death (Check only one, examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 🙎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number

State Registrar

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

**AUG 1** 6 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar		State of Ma	ryland .		tment of H ficate of L		and Menta	ıl Hygiei Reg.	2111	0	25	427
	Physicia		1. Decedent's Name		ast)						e of Death	Day 20	ear		of Death
	Medic Examin		4a. Facility Name (if		ve street and number)	401	4	b. City, Town, o			103/	4c. County of		02	737
	Funeral		5. Social Security N			(In yrs. last I		Baltime If Under 1 Year	If Under	r 24 Hrs. 8. Date	e of Birth	g	. Birthpl	ace (State	or Foreign
	Director		219-20-2 Usual Residence of	2287	1 □ M 2 🛣 F 82		Yrs.	Months Days	Hours	Min. (Moi Nov.	nth, Day, Yea	1927	. Birthpl Countr	MD_	
	and show lat	or	10a. State	10b. County		10c. City, To	own or Locat	ion					10	d. Inside	City Limits
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	s 23a or ust be n	Funeral D	10e. Street and Nur 4749 Gav	<sub>mber</sub> wain Dri	ve			10f. Zip Code 21043				Citizen of Wha	at Count	ry?	
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed	ried 2  Married 4  Divorced	12. Was Decedent Ev Armed Forces? 1 1 Yes 2 N If Yes, Give Year or Dates.	er in U.S.	If Y	s Decedent of Hes, specify Cuba	n, Mexica	igin? (Specify Yes n, Puerto Rican, e r:	or No- tc.)	14. Race - Black, V Specify:	America White, et Whi	C.	
Maryland 21215-0036	ithin 72 hou ene. • <b>than "nat</b> u <b>he Medica</b> l	Completed	(Spe	15. Decedent's ecify only highest conday (0-12)		<u>,                                    </u>	(Give kin life. DO l	t's Usual Occup d of work done o NOT use retired) strativ	during mos	•	Car	. Kind of Busin tonsvil mmunity	1.e	•	
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	nd 2 should saith and N n 27 is ma er trauma		19a. Informant's Na Diane Ki	·	(Type, Print) Daughter					er or Rural Route i Ellicot					
Baltimore,	Page 1 an ment of He ant: If iten ury or oth		20a. Method of Disp 1  Burial 2 4  Donation		☐ Removal from State	ceme	etery, cremat ntic C	on (Name of ory or other place remator	y 8	Date /12/2010	G1	en Burr	ie,	MD	
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E N EBox 687	To the Hospital or Attending Physician. The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending is completed filled in by the funeral director, page 2 should be detached for use as	Σ	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	Fetal de	eath 3 🗌 E	ctopic pregnand other (specify)	Эу	Ome		23d. Date o		y Day	Year
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$+ \sigma_{M} \mathcal{E}$ Division o	ttending death. stor: After the fune	Certificate:	1 Delatural 2 Accident 3 Suicide	5 ☐ Pending Investigati 6 ☐ Could not	ion August 9,	Year) / <b>2010</b> /	1500 h	M 1□	Yes 2	YNo Her	walk	Cer Sli She	- 7	all	ol mbor
Divis	ital or A urs after ral Direc lled in by		4 🗌 Homicide	determine	Beecho	(Specify)	sisste	d livi	ng ta	calify 10	or Town, St	Beechw	000	Ave	2
\$	he Hospital of in 24 hours at the Funeral D he Funeral D helpeted filled in	Medical	(Check 2	☑ Medical Exa	nysician: To the best of miner: On the basis of exaurse Practioner: To the b	amination an	d/or investiga	ition, in my opinio	on, death o	ccurred at the time	, date and pl	ace, and due to	the caus	se(s) and n	manner stated.
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#28	x (0)		30. Name and add	wess of person who	completed cause of dea CEBIZE Y 32. Registrar	ES.	900	cato.	n A	-3 Ne , Ba	Him	nove ,	MD	,21	229
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Louis Luck		1- For State Registrar	St	ate of Maryla	•	irtment o <i>tificate o</i> :		nd Menta	l Hygiene	Rea No	2011	0 25428
Physicia Medical Examir	n/	Decedent's Nam	e (First, Midd		00		uck		2. Date of De Month	Day	Year	3. Time of Death 2342 hrs
Medical Examin		· ·		ىد n, give street and nu	ee ımber)		4b. City, Town, o	or Location of [	August 6		County of Dea	
		5. Social Security		6. Sex	7. Age (In yrs. Ia	aet hidhday)	Baltimore	ear If Under 2	24Hrs 18 Date of B	licth (NANA/C	N/A	Birthplace (State or
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th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Nu	mber	2.7.22	I		10f. Zip Code			10g. Citize	en of What Co	ountry?
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21215-0036 Auld be filed within 75 Mental Hygiene. marked other than c event, the Medical		17. Father's Name George	(First, Middle, Luc	_					Name (First, Middle, stine Cr	_		
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More Pages 1 ent of Fi			Cremation Other Sp	3 Removal fro	om State Jos And	rebhot d Cren	rown F atory	/H	08/16/10	Ba	ltimoı	re,MD
Baltimore, permit. Pages I and Department of Heal Important: If item injury or other tra	1	21 nature Fu				2 <u>7</u> ¢	ame and Address	ss of Facility				ome PA MD 21217
Physician	+			complications that	used the death.							Approximate Interval
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احق ح ۲۵۵	剷	1 Yes 2 1 Part II. Other signi		ons contributing to	own death but not re	sulting in the u	nderlying cause	given in Part I	23e. Did t	tobacco us	se contribute t	to the cause of death?
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Division of Vital Records, ral or Attending Physician: The law require is after death.  *al Director: After this certificate has been siled in by the funeral director, page 2 should be	Completed	1							24a. Was	psy	prior to	autopsy findings available o completion of cause of
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of ling Ph After th	읽	27. Manner of Deat	h		of Injury Day,Year)	28b. Time of I		ury at Work?	28d. Describe	how injury	y occurred	
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Division of Vital    To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director.		( Cricon only		ysician: To the bes	-							
To the within To the comple	Med-	29b. Signature and	title of certifie	and manner st	tated.		29c. Licen	se number		29d. Da	ate signed (M	lonth, Day, Year)
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Offor				who completed caus Assistant Med			enn Street, E	Baltimore, N	/ID 21201			
Sta Registr	-	31. Date filed (Mont	h, Day, Year)	32 Re	gistrar's Signatur	hou	Kal					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No dent's Name (First, Middle, Last), 2. Date of Death 3. Time of Death Physician/ 1 1 Day 08 Month 2010 12:41A M Medical 4a. Facility Numb (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death christ Hospice <u>Baltimore</u> N/A If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F 067684 1947 Maryland **Director** 218-50-8500 63 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No N/A MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1040 E. 33rd Street Apt221 21218 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 

Yes 2 □ No Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐XNo Specify: Black 3 Widowed 4 X Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) 12th Grade College (1-4 or 5+) Line Worker **GMAC** any injury or other traumatic event, 17. Father's Name (First, Middle, Last) ige 1 and 2 should be filed it of Health and Mental H I: If item 27 is marked ot 18. Mother's Name (First, Middle, Maiden Surname) Clarence Lyles Alda Owens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5611 Haddon Ave., Gwynn Oak, MD 21207 Alda James(sister) 20a. Method of Disposition 20b. Place of Disposition (Name of Department of I 1 Burial 2 Cremation 3 Removal from State Joseph Brown F/H And Erematory 08/13/10 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licens 305ephodas.of Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. ot enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or linjury that initiated events resulting in death) Last physician the burial Physician/Medical Box 68760 d guipu IF FEMALE: of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month 4 ☐ Pregnant at time of death 9 ☐ Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, No 3 Probably 4 Unknown page 2 should . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No s after death.

I Director: After this certifica ed in by the funeral director, p Hospital or Attending Physician: Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: 욘 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined Medical 29a. Certifier 🔣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one)

State Registrar 31. Date filed (Month, Day, Year

DHMH 17 Rev 7/2009

1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day Year 2:20PM LOMBARDO JOSEPH AUGUST 2010 0 /Medical 4a. Facility Name (If not institution, give street and number) VA 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE

If Under 1 Year If Under 24 Hrs.

Davis Hours Min. LOCH RAVEN COMMUNITY LIVING CENTER 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 130-32-875 Hours 1**2** M 2 □ F Director Usual Residence of Decedent ould be filed within 72 hours after death with the Maryland Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country Funeral . Was Decedent Ever in U.S. Armed Forces? 1 No see 2 No lf Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 2 No 1 Tyes Specify: UM ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or,6+) Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (Fjrst, Middle, Maiden Surname, Be Pages 1 and 2 should ည Relationship (Type, Print) Tacy Seymour 19a. Informant's Name/ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, WA permit. Pages 1 and 2 s
Department of Health at
Important: If item 27 Is
any Injury or other trau RING 20b. Place of Disposition (Name of cemetery frematory or other) 20a. Method of Disgo 20c. Location - City or Tow 1 Burial 2 Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fungeral Service License 22. Name and 600 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CURONARY **Physician** ARTERY DISEASE, CONGESTIVE HEART FAILURE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. been signed by the attending physician should be detached for use as the buria Physician/Medical as the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 MELLITUS . PERIPHERAL VASCULLAR DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed CHRONIC 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No RENAL FAILURE 24a. Was an has autopsy CANGITENE RIGHT 2 No 1∐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA P this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending F within 24 hours after death.
To the Funeral Director: After 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Mr. D lan. U 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A I IN O R A C. TAN 3900 Luch RAVEN BLUG BALTIMURE, MD 21218 31. Date filed (Month, Day, Year)-Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First Middle, Last) 2. Date of Death Physician/ 2010 1:00 p M Rita J. Lunn 8 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1623 Ralworth Road Baltimore na 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth Birthplace (State or Foreign Country) Funeral Hours Min (Month, Day, Year) 4/3/1941 1 🗆 M 2 💢 F 69 Director 127-44-1722 Trinidad Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 XYes 2 No MD Baltimore na 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1623 Ralworth Road 21218 USA items death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. and Mental Hygiene. is marked other than "natural", or i þ 1 Never Married 2 X Married 72 hours after Maryland 21215-0036 1 Yes 2 No Specify Specify: Black 3 Widowed 4 Divorced Completed Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade Master's Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Miller Hospedales Agnes Antoine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau Andrew Lunn-Husband 1623 Ralworth Road Balto, MD 21218 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 1 ★Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) netery, crematory or other place King Memorial Pk8-17-2010 Randallstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H 21202 Balto, MD1101 E. North Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death ed by the a detached f Unknown 9 Unknown s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by hupertension Records, 2 1 No 3 Probably 4 Unknown cliverticulasis 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has e 2 autopsy performed? Yes 2 No page death? this certificate 1 Yes **Division of Vital** Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: 잍 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d, Describe how injury occurred 1 V Natural work? injury 5 Pendina within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8/13/10 025663 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 40th Baltorlow Md ulto 21214

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

anka

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Item 5 per fh g907 9-13-10 vt
State of Maryland 7 Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ESLIE AUMAN .25 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Future Care Pine View Hospice Clinton Social Security Number 255 If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
July 27, 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Georgia 1 🔀 M 2 🗆 F Months Days Hours Min. **Director** <del>5</del>-56-4072 1939 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland the Medical Examiner must be notified at Director 1 X Yes 2 ☐ No Maryland Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral **23**a U.S.A. 9106 Pine View Lane 20735 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Black Completed 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Wonder Bread 12 Baker To Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Idella Fitzpatrick Essie Leslie, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 11430 Wildmeadows St., Waldorf, MD 20601 Juanita Green (Sister) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 A Burjal cemetery, crematory or other place) 2 Cremation 3 Rem I from State 4 Denation 5 Other (Specify) 8/14/2010 Ebenezer Cemetery Pine Mountain, GA 22. Name and Address of Facility Lakes-Dunson-Robertson Funeral Home 21. Signa ure of F ineral Service Li 201 Hamilton St., LaGrange, 1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final SOPHA GEAL Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 attending p IF FFMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death 1 Yes 2 9 Unknown a 🗍 Unknown β Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Vinknown 24b. Were autopsy findings available 24a. Was an as 2 autonsy prior to completion of cause of death? rectificate has performed? Yes 2 No 1 ☐ Yes 2 ☑ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: ြု 1 🗌 Yes 2. No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation within 24 hours after death

To the Funeral Director:

completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 10/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVE, SUITE 218 AKHAM, 283 IMSNEEm MI

Registrar

DHMH 17 Rev 7/2009

State

Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 13, **Physician** 20 AM Larkins 2010 Crystal Aug. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Baltimore NA Future Care Irvington 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country)
 MD 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 220-18-9122 1 □ M 2 🛣 F 87 01 - 12 - 23Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evantment rust to modified at X X XYes 2 No Director Baltimore NA MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21217 USA 301 McMechean Street Apt.#412 death v Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. African filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No þ Specify: American 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Domestic Home maker 12th Grade 2yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event Luck Fielder Prudence Brown 19a. Informant's Name/Relationship (Type. Print) Niece 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21229Angela Larkins Lucas 29 N. Morley Street Baltimore, Maryland altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08-20-10 Arbutus, MD Arbutus Mem. Pk. Wylie Funeral Home P.A. 21. Signature of Funeral Service License 22. Name and Address of Facility 638 N. Gilmor Street Baltimore.MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final PULMONAR **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner EMBOLISM ULMONAR if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine as the burial-tran Due to (or as a consequence of): P.O. Box 68760. signed by the attending physician be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) ☐Yes 2☐No 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 → No 24a. Was an page 2 s has certificate 1□Yes 2⊅No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 A Residence 6 Other (Specify) 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 5 ☐ Pending investigation 1)☑ Naturai 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 3 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a, Certifier 1'🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1)0061765 JAHNOU

5V

State Registrar - QUALNOO 3350 WILKERS AVE #307 BACTIMORE MD 21229
Year) ---- 32. Registrar's Signature

31. Date filed (Month, Day, Year) --- 32. Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

		For State Registrar		State o	f Marylar			ent of H		and M	lental Hy			10	25	431
Physicia	ın/	1. Decedent's Name (Fi					tinoa	10 0/ 1	- Cutii		2. Date of De Month August		10.	ďaro		of Death
Medic Examin		4a. Facility Name (if not 9209 Bryan	institution, give	street and num				y, Town, or aure]	Location of	of Death	August	4	lc. County of	of Death		23 1
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I fire Zf is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		5. Social Security Numb	6 1	ex □ M 2 ∏ F	7. Age (In yrs. 89	last birthday) Yrs.	If Und Months	er 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir Apr 26		921	9. Birthp Count		e or Foreigr
	irector	10a. State 10 MD 1	b. County Howard			ty,Town orLo	cation							10		City Limits es 2 XXV
	Funeral Director	10e. Street and Number 9209 Bryan 11. Marital Status			dent Ever in U.	c 123		20723		gin2/Snor	cify Yes or No-	U.	S.A.			
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nit. Page 1 artment of ortant: If i injury or o		1XX Burial 2 ☐ 0 4 ☐ Donation 5 ☐ 21. Signature of Funera	Other (Speci	fy)		cemetery, crem nanuel 22	Chur	ch Ce	em.	8/14,	/2010 Home, E	Sc	aggsv	-		
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siciar certif irecto	o Be	25. Was case referred to examiner? 1 ☐ Yes 2 ☒ শ		Hospital:	Inpatient 2	I FD/Outrotion		Otho	r: Deat		only one) ne 5 XX Resi			<i>(</i> 0 ( <i>(</i> 1)		
ath. r: After this re funeral d	ertificate: To	27. Manner of Death  1 XXatural 5 2 Accident	Pending Investigatio	28a. Date of (Mont		28b. Time of injury		28c. Injury work	at	2	8d. Describe I					
in the hospital of Attending Frinsican: The law within 24 hours after death.  To the Funeral Director After this certificate has completed filled in by the funeral director, page 2 completed filled in by the funeral director, page 2.	O	4  Homicide	Could not be determined	28e. Place buildir	of Injury - At h	y)					28f. Location ( City or Tov	vn, Stat	te)			nber,
tne nosp thin 24 hor the Fune mpleted fi	Medical	(Check 2 L only one) 3 L	Medical Exam Certifying Nur	sician: To the be iner: On the bas se Practioner: T	is of examinatio	n and/or invest	tigation, in	n my opinio curred at the	n, death oc time, date	curred at	the time, date a	and plac ne cause	ce, and due te e(s) and man	to the caus ner as sta	se(s) and r ted.	nanner state
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DV		30. Name and address Paul Armst	rong, N	1.D. 14	201 La	urel Pa	Print) ark I	Drive	, Sui	te 1	02 La	urel	, Mar	ylan	d 20°	707
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25435 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 7:04 AM DUIS **Physician** 2010 tua /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🗆 F Days Hours Yrs May 26, 1933 MD 77 219-30-2387 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
nt: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2X No Director be notified MD Howard Savage 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number USA 8867 Washington St. 20763 Examiner must Funeral Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2XXNo
If Yes, Give
Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify. Specify: white <u></u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Plumbing q Plumber 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Minnie S. Fink Lewis D. Lutholtz 0 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Ann Lutholtz/ Wife 8867 Washington St., Savage, MD 20763 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of H
Important: If ite
any injury or ot
once. 1 Burial 2 Cremation 3 Removal from State August 2010 4 Donation 5 Other (Specify) Odenton, MD West Arundel Crem. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Donaldson Funeral Home, P.A. Ken Skile 313 Talbott Ave., Laurel, MD 20707 M01053 23a. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician Cardiagenic /Medical Due to (or as a consequence of) Examiner Myocardia Elevation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Year Month Day in the past 12 months? Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 Completed

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23e. Did tobacco u	se cor	ntribute to the cau	use of death?
1 N Yes 2	□No	3 Probably	4 🗌 Unknown
24a. Was an autopsy	24b.	. Were autopsy fil prior to complet	ndings available ion of cause of

Co				1 ☐ Yes 2 No 1 ☐ Yes 2 No		
Be (	25. Was case referred to medical		26. Place of Death (C	heck only one)		
년 B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐	□ DOA Other: 4 □ Nursing Home	ome 5 Residence 6 Other (Specify)		
Ë	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)  28b. Time of Injury  M	28c. Injury at Work? 1	28d. Describe how injury occurred		
dical Certificatio	3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined		ctory, office 28f	Location (Street and Number or Rural Route Number, City or Town, State)		
		hysician: To the best of my knowledge, death occuminer: On the basis of examination and/or investig and manner stated.		d due to the cause(s) and manner as stated.  at the time, date and place, and due to the cause(s)		
a a	29b. Signature and title of certifier	11	29c. License number	29d. Date signed (Month, Day, Year)		

29a. Certifier (check only one)		<ul><li>lan: To the best of my knowledge, dea</li><li>r: On the basis of examination and/or in and manner stated.</li></ul>			o the cause(s) and manner as stated. time, date and place, and due to the cause(s)
29b. Signature and	d title of certifier	1.	290	c. License number	29d. Date signed (Month, Day, Year)  AUGUST 9, 2070

	Holine /	10	l
30. Name	e and address of person	who completed cause of death (Item 23a) (Type, Print)	

600 North Wolfe St, Baltimore, MD, 21287

State

after death Director:

24 hours a

within 2

Division

Haitham 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25436 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OTIS LINZY Month 2010 12:46P M August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 5 Manasses Drive North East Cecil If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth
(Month, Day, Yea
April20 9. Birthplace (State or Foreign Funeral 1 X M 2 □ F Maryland **Director** 213-60-4465 58 1952 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Cecil 1 ☐ Yes 2X No Maryland North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21901 5 Manasses Drive U.S.A. items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 ☐ Yes 2 If Yes, Give 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 X Divorced Year or Dates Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) pernit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Drywall Finisher Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carl William Linzy Barbara Abrams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Caldwell Guy Road, Orlando, Florida 32828 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔲 Burial 2 📉 Cremation 3 🗆 Removal from State ArdentCremation, Inc. 8-12-10 Hanover, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee <sup>22. Name and Address of Facility</sup> Marzullo Funeral Chapel, P 6009Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. Medical resulting in death) Due to (or as a consciuence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-transit Exam that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death g 🗌 Unknown detached g 🔲 Unknown P.O. ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director. After this certifics completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Jamil Khatiri

AUG 1 6 2010

31. Date filed (Month, Day, Year)

111

West

32. Registrar's Signature

High

acks

Street,

Elkton Maryland 21921

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year ~ 30M D. Lowman Carole MU GUST 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Glen Burnie 4c. County of Death Anne Arundel Examiner Baltimore Washington Medical Center 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Mary) and Funeral 1 M 2 XF Days Hours Octonth, 24, Year 1943 Director 212-40-7011 66 Usual Residence of Decedent 10a. State 10b. County Director 10c, City, Town or Location 10d. Inside City Limits Glen Burnie 1 Tes 2 No Anne Arundel Marvland | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21060 331 Gatewater Ct. Apt. 202 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc ģ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. White Completed 3 Wildowed 4 Divorced Specify. 15. Decedent's Education 16a. Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 72 } Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event". 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Dolores Ashburn С. Elmer Muir 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 331 Gatewater Ct., Apt. 202, Glen Burnie, MD 21060 Lewis L. Lowman, Sr., Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Balttmore Cremato @ Loudon Park 1 Burial 2 X Cremation 3 Removal from State 8/16/10 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Loudon Park Funeral Home <u>3620 Wilkens Ave., Baltimore, MD 21229</u> Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one caus Immediate Cause (Final disease or condition resulting in death) 136 Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last

Physician/ Medical Examiner

attending physician and for use as the burial-transit

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n 24 hours after death.

ne Funeral Director: After this of inleted filled in by the funeral dire

or 28a-f shov

within 72 hours after death with the Maryland than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at

Maryland 21215-0036

Baltimore,

AN30

by Physician/Medical Be Completed ၉

IF FEMALE:

23b. Was decedent pregnant

31. Date filed (Month, Day, Year)

AUG 1620

,	Due to (or as a consequence of):	MOIOVASCULAR
	Due to (or as a consequence of);	DIGG
b	Due to for as a consequence of y.	
с	Due to (or as a consequence of):	
d		

3 Ectopic pregnancy

23d. Date of delivery

AUGUST 12, 2010

PASAUGNA MD 21122

23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year 1 Yes 2 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DIABETES 1 Yes 2 No 3 Probably 4 Unknown EMPHYSEMA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 Yes 2 No Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending Accident Investigation 1 Yes 2 No 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

D 21776

RITCHIE MIGHWAY

State

within 2

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

DHMH 17 Rev 7/2009

Registrar

8021

MO

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUNDRA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year largaret 6:25AM August ,2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BRITIMORE Secours Hospita 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 30-3965 1 🗆 M 2 🕱 F Months Days Hours Min (Month December South Carestina Director 28a-f shov 10a. State 10b. County other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MARYLAND DALTIMORE 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a U SA 21216 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11, Marital Status 14. Race - American Indian, Armed Force Black, White, etc. ò þ 1 Never Married 2 Married Yes 2 No 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates "natural", Completed 3 Nidowed 4 Divorced African HMERICAN 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. King of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. BO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) PER Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, MABEL Ellison ൧ LSaac permit. Page 1 and 2 should to Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAMION Road -3012 LYHHE BALTIMORE MARYLAND 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) injury or awings, Milk. 4 ☐ Donation 5 ☐ Other (Specify) Fanceal Securce ure of Funeral Service Licensee 22. Name and Address of Facility NANCY M. WALLACE FORCEAL SECURE 3405 W. FRANKLIN STREAT BALLIMORE any m. Cla MARYLAND 21229 Ptd 1. Interfee disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or he in failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Cancer with colon disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence or, Examir sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician the burial Physician/Medical 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No for Day Month Year 1 Yes 2 J the signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, Dutansion 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform certificate 2 110 2 1 Yes or Attending Physician: 25. Was case referred to medical of Vital funeral director, Be 26. Place of Death (Check only one) examiner? 2**V** No Other: 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending To the Hospital or Attendin, within 24 hours after death.

To the Funeral Director; Afte completed filled in by the fun Division 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier 2 🗌 3 🔲 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marcia Cort mp 2000 W. Bastmore Balforon 31 Date filed (Month. 32. R State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Year Janie Mills 08 05 2010 Medical Mae 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 506 Shamrock Lane Pikesville Baltimore Co. . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs, last birthday, **Funeral** Days 1 M 2 K F Months 1070171922 S.Carolina 219-20-6998 87 Director Usual Residence of Decedent 28a-f shov ms 23a or 28a-f shor must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo MD Baltimore Co. Pikesville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 506 Shamrock Lane 21208 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14, Race - American Indian 11. Marital Status Examiner Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. o. þ 1 Never Married 2 Married 2 X No Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: Black "natural", Completed 3 Divorced 4 Divorced th and Mental Hygiene. 27 is marked other than "natul traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 7th Grade Canning Co./Inspector Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Nathaniel Essie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra John Mills(husband) 506 Shamrock Lane, Pikesville, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Mem. Park 08/12/10 Baltimore, MD Joseph H. Fulton Ave., Baltimore, MD 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ malignent pleural efficien disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** 3yerrs breest wou Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Day Month Year cate has been signed by the page 2 should be detached g 🗌 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 🗌 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury 28b, Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) **M**Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO020664 8/9/10 Kichenol C Borg 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard A. Berg in D. Suite 450; 10755 Fills Rd. Luther Wie, had 21093 31. Date filed (Month, Day, Year) 32, Redistrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month vertean 3:07 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death COUNT 1 General Columbia Mospita Howard If Under 1 Year If Under 24 Hrs. 8, Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min. 1 M 2 NF Month, Day, Year) Country) 1C Director Yrs. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Dies 2 D No 10e. Street and Number 10g. Citizen of What Country? Funeral 122 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Completed by 1 Yes 2 No Maryland 21215-0036 1 Yes 2 No Specify. Black Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SSISTANL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) laylor Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory Surial 2 ☐ Cremation 3 ☐ Removal from State Saltimore 12010 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility ND 21207 pulto 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician otic shoc disease or condition Medical resulting in death) r as a consequence of) Examiner bouteremi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed clearbitus Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Year 5 Other (specify) 9 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ the funeral director, page 2 should be 2 No Completed Stage rena 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director. After this certificate has autopsy performe death? 1 ☐ Yes 2 ☐ No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes Other: 2 No Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Natural 5  $\square$  Pending work 1 Yes 2 No Investigation Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Gertifying Nurse Practioner: To the best of my Imowledge, Seat orinumed at the time. data and place, and due to the causely) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D56245 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Melinda Kountsiper, MD Howard County Gen Hosp. Columbia MD 31. Date filed (Month, Day, Year) 1 6 2010 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August Month Medical acility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death (1 A. 4 716 8. Date of Birth (Month, Day, ecurity Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 N Months Min Director 16Yrs Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Nes 2 □ No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 99 Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 2 No ☐ Yes Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No 3/ac Specify. Completed 3 ₩idowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Informant's Name/Relationship (Type, or Rural Route Number, Matthews 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Months Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Month Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, The law requires 2 🗌 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Funeral Director: After this certificate of completed filled in by the funeral director, page 1 Yes Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifies 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 😾 Other (Specify) itospice 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) th and address of person who completed cause of death (Item 23a) (Type, Print) COOPER MD 7141 Curit TIMOVE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 6 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2010 6:09 Norma Elizabeth Minton August /Medical a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8800 Walther Blvd. #4618 Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 9. Birthplace (State or Foreign Country)
1929 Massachusetts 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Mar. 23, **Funeral** 1 □ M 2 □ vF 025-22-6638 81 Mar. Director Usual Residence of Decedent 10a. State 10c, City, Town or Location 10d. Inside City Limits show event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No · 28a-f Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code items 23a or 21234 USA 8800 Walther Blvd. #4618 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 ☐ Married o, Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🛣 No Specify: 2 3 X Widowed 4 ☐ Divorced 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Dutchess County Elementary/Secondary (0-12) College (1-4or 5+) Dept. of Health Secretary Important: If item 27 Is marked other any Injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Walter Reynolds Frieda Melvin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21212 108 Enfield Road; Baltimore, Thomas Minton / son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation ☐ ☐ Other (Specify) Calvary Cemetery 8/16/2010 Poughkeepsie, NY 21. Signature of Furer Pervisor Lig 22. Name and Address of Facility 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final arterioscleratic Cardiovascular disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be execute sician and burial-trans Due to (or as a consequence of): ending physician ause as the burial-Physician/Medical nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) signed by the a ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≦ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No Certification: To within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified H 0052365 August 9, 2010

State Registrar

DHMH 17 Rev 1/2001

, 8800 Walther Boulevard, Parkville Maryland 21234

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Ronald Jeffreys

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jane Ellen Marzullo August ነื0, 20 ነื 12:11PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🕅 F Months Hours March Day 4 Director 213-46-2410 66 1944 Maryland Usual Residence of Decedent or items 23a or 28a-f show and 2 should be filed within 72 hours after death with the Maryland Heatth and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location Injury or other traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits 1 Yes 2 No Maryland Harford Fallston 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 3215 Suffolk Lane 21047 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗵 No Black, White, etc. <u>6</u> 1 Never Married 2 X Married 21215-0036 1 ☐ Yes 2 X No Specify: and Mental Hygiene. If Yes. Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Frederick Stromyer Katherine Showalter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Joseph Marzullo (Spouse) 3215 Suffolk In, Fallston, Maryland 21047 permit. Page 1 and 2 Department of Health Important: If item 2 any Injury or other tonce. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State August 14. 1 X Burial 2 Cremation 3 Removal from State Highview Mem. Gardens 4 ☐ Donation 5 ☐ Other (Specify) 2010 Fallston, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Eacility Evans Funeral Chapel & Cremation Services — Bel Air 3 Newport Drive, Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical Adenocarcinoma disease or condition resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any list in the claim cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be extanced from a filter death.
Funeral Director: After this certificate has been signed by the attending physicial Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death Month Day Year been signed by the should be detached a ☐ Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No After this certificate has funeral director, page 2 s ardiac 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 \( \text{\subset}\) Nursing Home \( 5 \subseteq \text{Residence} \) 6 \( \text{\subset}\) Other (Specify) Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Naturai 5 Pending Accident Investigation in 24 hour.
the Funeral Directory filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 10056488 9010 August 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21031 D 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

State

Registrar

IME

31. Date filed (Month, Day, Year) AUG 1 6 2010 WILKENS

BAZINONE

AVE

21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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200

32. Registrar's Signature

LAM IMDA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Physician/ Month 2034 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NEVERSITY OF Maryland Madical ltim 5. Social Security Number If Under 1 Year If Under 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Y 1 M 2 F Country) 44 Yrs. Director 86 0300 213 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d, Inside City Limits Director MD n/a Baltimore 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 518 N. Linwood Ave. 21205 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 X Never Married 2 ☐ Married Yes 2 X No Yes, Give 2 1 Yes 2X No Specify. Specify:Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th employed Day Care Provider Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Benjamin F. Leola Fleming McKay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2847 Sarah Scott (aunt) Carver Rd. Baltimore, Md. , 2010<sup>20c.</sup> Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 X Cremation 3 Removal from State green Mount Crematory or other place) Aug Breen Mount Crematory 4 Donation 5 Other (Specify) Baltimore, Md 21. Signature of Funeral Service Licensee calvin B. Scruggs Funeral Home 1412 E. Preston St. Balto,Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ + month disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) sician and burial-transit that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death g ☐ Unknown signed by the a Id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires t within 24 hours after death.
To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autonsy performed Y Yes 2 No death? 1 ☐ Yes 2 🗹 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 **Z** No 1 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? injury 1 Matural 5 Pending 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number NPI 1124253661 DEA! AUY 176435819745 MD. 1051 Jent 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

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AUG

Baltimore, Maryland 21215-0036

Box 68760

P.O. |

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Year 6:11 Mullen 2010 Marie E Medical August 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BALTIMORE GLEN ARM ) weet water LANE If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8 Date of Rirth Funeral Days 1 - M 2 X F (Month, Day, Director 01-09-1917 TRIN ADAD Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD ARM 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral USA bweet water have 21057 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?.

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. MARYLAND STATE OF oblector Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ and 2 should be Health and Metem 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21057 19a. Informant's Name/Relationship (Type, Print) LANC permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr DWEETWATER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Rematory -12-2010 Signature of Euneral Service Licensee 22. Name and Address of Facility 2/34 Willow Backins 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Athonos clerote disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death ed by the a 9 Unknown P.O. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 3 ☐ Probably 4 ☐ Unknown 1 Tes cate has been sig ; page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was an autopsy performed the Hospital or Attending Physician: The law certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 1 Tyes 2 🗹 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natura 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 3 
Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mian-D CD

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (MA)

Balt more

2120

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			epartment of Health and Certificate of Death	Reg.	CUIU CU441
Physic /Med		Decedent's Name (First, Middle, Last)     Dora Ann Morgan		2. Date of Death Month August	3. Time of Death 13 2010 12:45P M
Exam		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat	h	4c. County of Death
		Future Care - Canton Harbor	Baltimore  If Under 1 Year   If Under 24 Hrs	8. Date of Birth	N/A
Funera Director		210-14-3330	Months Days Hours Min.		9. Birthplace (State or Foreign Country) Maryland
land Dw		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits
Mary I-f sho	to	Maryland Worcester	Ocean City		1 X yes 2 □ No
th the	lrec	10e. Street and Number	10f. Zip Code	10g.	. Citizen of What Country?
ath wi	ral	203 33rd Street Apt. 303	21842		USA
ter de	Funeral Directo	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 反 No	<ol> <li>Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer</li> </ol>	to Rican, etc.)	14. Race - American Indian, Black, White, etc.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or Items 23e or 28a-1 show any injury or other treumatic event, it is Nedical Examination in will be a ministered.	þ	3 ☑ Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify: White
"netu	etec	15. Decedent's Education 16a. [ (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of wo. life. DO NOT use retired)	rking 161	b. Kind of Business/Industry
withir iene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Manager		eafood Business
e filed al Hyg l other	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Nar	me (First, Middle, Mai	den Sumame)
yian ould b Menta warked	70	Gerald Scott		May Reckar	
d 2 sh th and 7 le m treum		19a. Informant's Name/Relationship ( <i>Type, Print</i> ) 19b.  Gerald Morgan - Son 203	Mailing Address (Street and Number or Ru 3 33rd Street Apt		ity or Town, State, Zip Code) an City, MD 21842
S 1 an f Heal item 2	1	20a. Method of Disposition 20b. Place of I	Disposition (Name of crematory or other place)		c. Location - City or Town, State
Page nent of int: If		1 Burial 2 Micremation 3 Hemoval from State	Service Corp. 08-	16-2010 To	wson, Maryland
permit. Departr Importe any inju		21. Signatury of Funeral Service incensee	22. Name and Address of Facility		5 Harford Road
707 40		23a Part I Enter the Jease or complications that caused the death. Do no	Leonard J. Ruck, In		timore, MD 21214
Physician		23a. Part1. Enter the disease, or complicit for s that caused the death. Do no shock, or heart fillure. List only on you use on each line.  Immediate Cause (Innal disease or condition.			Unset and Death
/Medical		disease or condition resulting in death)  a	structure fillonon	de Doc	ang .
Examiner		Sequentially list conditions, b.	Λ.		
rted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ų:		
an and rial-tra		that initiated events c.  resulting in death) Last  Due to (or as a consequence of	f):		
sate be executed physician and the burial-transit	dical	d			
certific	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
death e atter	Physician/Med	23b. Was decedent pregnant in the past 12 poinths?    Yes 2   No	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year
at the day the etache	Phys	9 Unknown		00- Bida-b	A illustrate the course of death 2
v requires that the death certificate been signed by the attending phashould be detached for use as t	by	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	1 Yes	cco use contribute to the cause of death?  2 No 3 Probably 4 Unknown
w requir been si should	letec			24a. Was an	24b. Were autopsy findings available
The law te has lage 2 s	Completed			autopsy	prior to completion of cause of
ding Physician: The land. After this certificate ha funeral director, page	BeC	25. Was case referred to medical examiner?		ath (Check only one)	
Physic this c	2			Home 5 Residence	ee 6 Other (Specify)
iding P th.: After funera	tion		ime of jury 28c. Injury at Work?  M 1 Yes 2 No	200. Describe now	injury security
To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification:	3 Suicide 6 Could not be 4 Homicide determined building, etc. (Specify)	m, street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
urs aft					
To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	Medical	29a. Certifier (Check only one)  1  Certifying Physicien: To the best of my knowledge, (Check only one)  2  Medicel Exeminer: On the basis of examination and and manner stated.	death occurred at the time, date and place For investigation, in my opinion, death occur	e, and due to the caus urred at the time, date	;e(s) and manner as stated.  and place, and due to the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier	29c. License number		. Date signed (Month, Day, Year)
		De cuerqua oaner M.D.	D16619	A	igust 13, 2010
1		30. Name and address of person who completed cause of death (Item 23a) (1	Type, Print) st CT. Towson, MD 21	1286	
7		Corazon Vergara-Soares 3 Midcres  31. Date filed (Month, Day, Year) 32 Registrar's Signature	ot OI. TOWSOII, PID 21		
Regis	tate trar	AUG 1 6 2010 A	hordes		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ State		partment of Health and N	fental Hygier	le 2 U I U	25448
			Registrar  1. Decedent's Name (First, Middle, Last)	•	ertificate of Death	Reg. I	40.C U I U	3. Time of Death
	∕sicia ∕ledic		Charlie E.	Mims		Month D8	Day Year	12: 40AM
- market	amin	er	4a. Facility Name (if not institution, give street Union Memorial	Hospital	4b. City, Town, or Location of Death Bortimore	1	4c. Dounty of Death	
Dire			5. Social Security Number  04-18-6397  Usual Residence of Decedent	7. Age (In yrs last birthday, 2 $\square$ F	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8 Date of Birth	1925 1925	pplace (State or Foreign
Maryland 28a-f show	tified at	Director	10a. State 10b. County  MD NA	Bottime				10d. Inside City Limits  1  Yes 2  No
n with the is 23a or 2	nust be no	Funeral Di	10e. Street and Number 1419 Old York R	7D.	10f. Zip Code 2/2/2	10g.	Citizen of What Cou	intry?
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygierie. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show	I Examiner n	ρ	1 Newer Married 2 Married 1 3 Widowed 4 Divorced	rmed Forces?  ✓ Yes 2 ☐ No Yes, Give ear or Dates.	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1  Yes 2 No Specify:		14. Race - Ameri Black, White, Specify: Black	
Baltimore, Maryland 21215-0036  sermit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene important: If item 27 is marked other than "natural", o	it, the Me io	e Completed	9th	mpleted) (Give	edent's Usual Occupation e kind of work done during most of worki DONOT use retired) DONOT	ng	. Kind of Business Ir get Met	. 1
yland Jid be filed Mental Hy narked oth	atic even	To Be	17. Father's Name (First, Middle, Last) WYSES MIMS		18. Mother's Name	First, Middle, Maide	erson	
and 2 should all the and and 27 is n	her traum		19a Informant's Name/Relationship (Type, Pr	y- Sis-in-law	iling Address (Street and Number or Rura 4423 Old YOCK	DO. BALT	5 mo 21	212
timore: Page 1 st tment of 1 tant: If ite	jury or ot		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	val from State 20b. Place of Disposer	position (Name of ematory griother place)  B-17	Date 20c.	Location - City or T	own, State
Balti permit. Departr Imports	any in		21. Signature of Juneral Service Licenses		22. Name and Address of Eacility Full 46 FREDHILTON PAS	neral Hon	ne P.A.	229
Physic			23a. Party Enter the disease, or complication shock or heart failure. List only one cau Immediate Cause (Final disease of condition	se on each line.	nter the mode of dying, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death 3 DAYS
Med Exam			resulting in death)	Due to (or as a consequence of):  MESENTERIC	ISCHEMIA			NEEK
pe :	Sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to (or as a consequence of):				<u> </u>
'60 ate be executed	ounal-tran	dical Exa	that initiated events c. — resulting in death) Last	Due to (or as a consequence of):				
3760 ficate b g physic	as the r	Medic	d					
Division of Vital Records, P.O. Box 68760  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and the property of the transfer of the tr	Shed for use		in the past 12 months?	yes, outcome of pregnancy  Live Birth 2  Fetal death 3 Pregnant at time of death 5 Unknown	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of deliv Month	very Day Year
S, P.O	Id be deta	ا ۾	Part II. Other significant conditions contribu	ting to death but not resulting in the	underlying cause given in Part I.		use contribute to t	the cause of death?
/ital Record sician: The law requ	age z snou	Completed				24a. Was an autopsy performed?	prior to co death?	opsy findings available ompletion of cause of
ician: T	ector, p	Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospit	al:	26. Place of Death (Check		10 100	
n of V ing Phys After this	uneral di	ate: To	T Tes 2 De NO	1 Inpatient 2 ER/Outpatie la. Date of injury (Month, Day, Year) 28b. Time of injury	ent 3 DOA 4 Nursing Ho  28c. Injury at  work?	me 5 Residence 28d. Describe how inj		y)
ivisior or Attend after death Director:	in by me r	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	e. Place of Injury - At home, farm, st building, etc. (Specify)	M 1 Yes 2 No	28f. Location (Street a City or Town, Sta		al Route Number,
Hospital 24 hours a Funeral I	sted rilled	Medical (	(Check 2 L Medical Examiner: Or	n the basis of examination and/or inve	n occured at the time, date and place, and estigation, in my opinion, death occurred at	the time, date and place	ce, and due to the ca	ause(s) and manner stated.
To the within	compie		only one) 3 ☐ Certifying Nurse Prace 29b. Signature and title of certifier	ctioner: To the best of my knowledge.	, death occurred at the time, date and place 29c. License number	29d. [	Date signed (Month,	Day, Year)
DHT!			20 Name and address of		4.0. AT 2:43 8 9 4 6	Au	GUST 8	, 2010
47,	1		30. Name and address of person who comple	MIP. , 200 EAS		KWY, BAL	TIMORE,	MD, 21218
	State jistra	7	31. Date filed (Month, Day,-Year)	32. Registrar's Signature	tarked			

10-06003		Please Type or Print in Black Indelible Ink. Ensure Al		
Steven McEach	iem	State of Maryland / Department of Health and Months    1-For State	ental Hygiene	2010 2544
DI	:/	Registrar Certificate of Death	2. Date of Dea	Reg. No.
Physic Modiçal Exam	ıan/ iner		Month	Day Year 4500 has
Y		STEVEN McEACHERN  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Locati	August 10	4c. County of Death
		Union Memorial Hospital Baltimore		N/A
Funeral			Under 24Hrs. 8. Date of B	irth(MM/DD/YYYY) 9. Birthplace (State or
Director		217-84-3497 1XM 2F 45 Yrs. Months Days Ho	lours Min. 8-24	-1964 Foreign Country)MARYLAND
		Usual Residence of Decedent		
Maryland 28a-f show any 1 at once.		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
land f sho	ō	MD. BALTIMORE TOWSON		1 Yes 2 No
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland feath and Mental Tygeine. item 27 is marked other than "natural", or items 23a or 28a-f shotranmatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What Country?
ith the 23a o notifi				USA
ath wi	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic 14. Typever Married 2 Married Armed Forces? 15. Was Decedent of Hispanic 16. If Yes, specify Cuban, Mexic		<ul> <li>14. Race - American Indian, Black, White, etc.</li> </ul>
er de			scifu:	Specify: DT A CTZ
urs afi tural' amine	d b	l or Dates:		16b. Kind of Business/Industry
72 hor 1 "na	ete	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO N	IOT use retired)	,
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Completed	a -12- LABORER		GROCERY STORE
5-00% iled withi Hygiene 3 other th			other's Name (First, Middle,	Maiden Surname)
2121; hould be fill and Mental Is is marked tic event, p	Be.		ALMA RIGSBY	
MD 2121 d 2 should be f Ith and Mental n 27 is marked numatic event,	To			
re, MD 21215-0036 s I and 2 should be filed within 72 hours after death with the Maryland of Heat and Mental Hygene. If item 77 is marked other than "natural", or items 23a or 28a-f She ner traumatic event, the Medical Examiner must be notified at once		TRACY McEACHERN(SISTER) 8245 PLEASANT PI  20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,		SON MARYLAND 21286  20c. Location - City or Town, State
Ore ges 1 a for H		1 K Burial 2 Cremation 3 Removal from State crematory or other place)	, Bato	255. 255d.isi. Sky er rewii, skate
Baltimore, permit. Pages I a Department of He Important: If ite		4 Donation 5 Other Specify: MT ZION CEMETERY 21. Si natur of F eral Servi Li	8-17-2010	BALTIMORE, MARYLAND
Baltimore, MI permit. Pages 1 and 2 s Department of Health as Important: If item 27 injury or other trauma		D. HIBBER		
Physician		23a P. 7 Enter the disease or complications that caused the death. Do not enter the mode of dving, such a	as cardiac or respiratory arr	ETIMORE MARYLAND 2121 est, shock, or heart Approximate Interval
/Medical		Hypertensive Cardiovascular	Disease	Between Onset and Death
Examiner	l, b	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):		
		Sequentially list conditions, b		
	iner	if any, leading to immediate Due to (or as a consequence of):		
t -	Examiner	(Disease or injury that initiated events resulting in death) Last Use to (or as a consequence of):		
executed an and al - transit				
ਂ ਸ਼ਵ	dical		11 G911 eg	1
760 icate l	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the		23d. Date of delivery
OX 68/ eath certific attending	ian	past 12 months?  1 Live birth 2 Fetal death 3 Ecto 4 Pregnant at time of death 5 Other (Specify)	topic pregnancy	Month Day Year
Box ie death the atte	ysi	1 Yes 2 No 9 Unknown 9 Unknown		
that the			Part I. 23e. Did to	obacco use contribute to the cause of death?
ires that signed I be deta	Completed by		1 Yes	s 2 No 3 Probably 4 V Unknown
cords aw requi	lete		24a. Was autop	
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tal Rection: The certificate ector, page			ath (Check only one)	2 10 10 2 10
Vita ysicia direc	o Be		Nursing Home 5	Residence 6 Other:
Division of Vital Records, tal or Attending Physician: The law requires after death.  al Director: After this certificate has been siled in by the funeral director, page 2 should be	=	27 Manner of Death 28a Date of Injury 28b Time of Injury 28c Injury at W	/ork? 28d. Describe	now injury occurred
ion trendi leath. tor:	읉	Natural 5 Pending 1 Yes 2 Accident Investigation	No	
ivis or A after of Direc	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building,	g, etc. 28f. Location (8 or Town, S	Street and Number or Rural Route Number, City state)
Spital nours neral	è	4 Homicide determined (Specify)		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death		
To viti	Me	and manner stated.  29b. Signature and title of certifier  29c. License numb	per	29d. Date signed (Month, Day, Year)
		Third M. Big To A O.C.M.E.	OCME	August 11, 2010
	1	30. Name and address of person who completed cause of death (Item 23a)		
	1	Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, E	Baltimore, MD 21201	
		31 Date filed (Month, Day Veer) 32 Registrar's Signature		

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items 10e,19a per fh g906 8-18-10 vt

State of Maryland / Department of Health and Mental Hygiene
amend item 19a per fh g906 8-20-10 vt

Certificate of Death

Reg. No. 25450 State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Physician/ Month Tam Thi Nguyen August 6:10A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Genesis Multi Medical Center Towson Balto. Social Security Number Age (In yrs. last birthday)
75 Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) [arch 10,1935 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Hours Min. Vietnam Director 215-43-8403 March Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Md Balto. Nottingham 10e. Street and Number **Ridge1ys** 10f. Zip Code 10g. Citizen of What Country? Funeral USA Ridgley Choice Dr. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 24 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc Completed by 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 Asian 1 ☐ Yes 2 📈 No Specify: Specify: 3 

▼ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 5 th College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Xuan T. Nguyen Tiem H. Nguyen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8729 Ridgely Choice Dr. Nottingham. Md. 21236 19a. Informant's Name/Relationship (Type, Print) Tri<u>nh <del>Pheng</del></u> DTR Phung 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 8-13-2010 Bayview Balto, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature f Funeral Service Licersee Schimunek Funeral Home 22. Name and Address of Facility 9705 Belair Road Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ disease or condition resulting in death) ocerdin Medical Due to (cr > a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be ex Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 5 Other (specify) ed by the a detached t 9 Unknown 9 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 № No 3 □ Probably 4 □ Unknown : After this certificate has been si funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy perform 2 No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5  $\square$  Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined edical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 53462 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd. MP 32. Registrar's Signature State Registrar

Registrar DHMH 17 Rev 1/2001

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CUTZER

AUG 1 6 2010

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

127220

el Blvd, White March,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death AUG 9, 2010 Physician/ OSCAR NORDMAN  $p_{M}$ 430 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SUNRISE AT MONTGOMERY VILLAGE ASSISTED LIVING MONTGOMERY VILLAGE MONTGOMERY 8. Date of Birth (Month, Day, Year) MARCH 21, 1 If Under 1 Year If Under 24 Hrs. Social Security Number 6 Sex Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) Days Hours 1XX M 2 □ F Director 160.24.4109 90 **UKRAINE** Usual Residence of Decedent "natural", or items 23a or 28a-f show idical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1XX Yes 2 □ No MONTGOMERY MONTGOMERY VILLAGE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19310 CLUB HOUSE ROAD 20886 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married 2 No 1XX Yes Baltimore, Maryland 21215-0036 1 Yes 2 XXNo Specify: WHITE 3XX Widowed 4 □ Divorced Completed Year or Dates 27 is marked other than "natur r traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) and Mental Hygiene. 4+ **ENGINEER AEROSPACE** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ KARLIS NORDMAN MELANIE BUROV 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr KAREN CUCURULLO DAUGHTER 16620 MUSIC GROVE COURT, ROCKVILLE, MD 20853 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 XX remation 3 Removal from State BAYVIEW CREMATORY, INC. 4 ☐ Donation 5 ☐ Other (Specify) AUG.12, 2010 BALTIMORE, MD 22. Name and Address of Facility
ELNK FUNERAL HOME, P.A. 21. Signature of Funeral Service M01148 426 CRAIN HWY. S. GLEN BURNIE MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ASPIRATION PNEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner IDIOPATHIC PULMONARY FIBROSIS **YEARS** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Year Pregnant at time of death Dav should be detached 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by **DEMENTIA** 1 ☐ Yes 2 ☐ No 3 XX Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 this certificate has performed? Yes 2 XXNo 2XX No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ASSISTED LIVING Hospital: Other: 뎯 1 🗌 Yes XX No 4 ☐ Nursing Home 5 ☐ Residence 6 Other (Speci 1 Inpatient 2 ER/Outpatient 3 DCA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer XX Natural 5 Pending work? 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours To the Hospital Medical 29a, Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Definition of the basis of examination and/or investigation, in my opinion, death paceured at the time, date and place, and due to the cause(s) and manner stated.

Contifying Nurse Practionar To the basis of examination and/or investigation, in my opinion, death paceured at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D31391 suball AUGUST 11, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

SUHAIR ABULTARAG

31. Date filed (Month, Day, Year)

AUG 1

32. Registrar's Signature

604 SOUTH FREDERICK AVE. #401, GAITHERSBURG, MD 20877

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

William Pinkard State of Maryland / Department of Health and Mental Hygiene 25453 2010 1. For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Medical Examiner 0906 hrs August 11, 2010 PINKARD WILLITW . 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore Washington Medical Center** Glun Burnie Anne Arundel 5 Social Security Number 6 Sex If Under 1 Year If Under 24Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** 08=01-1938 Months Davs Hours Director 212-36-7415 1 XM 2 F Country) MD Yrs Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits CLENBURNIE A.A.CO MD 1 X Yes 2 No 28a-f show or items 23a or 28a-f shormust be notified at once. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 這 USA 21060 7929 FREETOWN RD Funeral 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 Married 2 X No Yes Specify: BLACK "natural", or ore, MD 21215-0036 es 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. 1 Yes 2 No specify: 3 Widowed 4 Divorced If Yes, Give Year event, the Medical Examiner Š or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) CONCRETE MASON 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) HILDA PEARMAN WILLIAM R. PINKARD, SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it: If item 27 is n SEVERNA PK., MD 21146 415 MC BRIDE LA., AVONETTE PINKARD/DAUGHTER 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, ASBURY TOWN NECK U.M. 08/19/10 | SEVERNA PARK, MD 4 Donation 5 Other Specify 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 21. Signature of Funeral Service Licenses mes ai 1701 LAURENS ST., BALTO., MD 21217 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line een Onset and /Medical Death a Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician and led for use as the burial - transit Physician/Medical UNPENDED AMENDED Box 68760 IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy edent pregnant in the Live birth 3 Ectopic pregnancy Month Fetal death Day Year past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Þ 1 Yes 2 No 3 Probably 4 Unknown Completed ficate has been si , page 2 should b 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has performed? death? ✓ Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other Nursing Home 5 Residence 6 Other this 1 🗸 Yes 2 No ٩ After 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Pending 1 Yes 2 No Director: 24 hours after death. 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined To the Funeral 4 Homicide 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 12, 2010 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Melissa Brassell, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Registrar's Signature State arked Registra

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OMonth 40000 15:50BW 5010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BACILYORE とうしゅう じゅ ロットックロインカロ はくしんりん BAUTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, July 7. Social Security Number 6 Sex 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 ★ M 2 □ F Hours Maryland Director 214-44-6047 64 1946 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director Dundalk Baltimore 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1327 North Point Road 21222 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces? Black White etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Martin Marietta Laborer 12 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be file tment of Health and Mental I tant: If item 27 is marked o n and Mental I ည William Bodine Doty Ida Gertrude Doty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sister-In-Law 1327 North Point Road, Dundalk, Maryland Margaret Doty 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot August 16. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematroy Baltimore, Maryland 2010 Sk native of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. none 21222 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease, Approximate Interval Between Onset and Death Immediate Cause (Final Physician BOURD CONOD disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical requires that the death certificate be P.O. Box 68760 attending physi IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death s been signed by the sahould be detached 1 ☐ Yes 2 ☐ Unknown q | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a Was an Hospital or Attending Physician: The law 124 hours after death.
 Funeral Director: After this certificate has t page 2 s autopsy performed? Yes 2 No 25. Was case referred to medical examiner? Division of Vital funeral director, 26. Place of Death (Check only one) Be 2 🗹 No Other: ျှ 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred M Natural 5 Pending injury work? 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one To the Within To the 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 01 5212234

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who complete

31. Date filed (Month, Day, Year) AUG 1 6 2010

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Charles starting ashistage four koor over

d cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #20c perFH G906 8/16/2010 JH
State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2 0 102 Bertha A. Prichard 10:00AM August Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Sparrows Point 2121 Sparrows Point Road Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days (Month, Day, Year) 4-19-1914 1 □ M 2 🗶 F Months Hours Min. 262-88-0313 96 **Director** ŴV Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director "natural", or items 23a or 28a-f s dical Examiner must be notified 1 X Yes 2 No MD Baltimore Sparrows Point 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 2121 Sparrows Point Road 21219 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: If Yes Give White Completed 3 Nidowed 4 Divorced al Hygiene. d other than "natura event, the Medical E Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Hote</u>l 8 <u>Manager</u> Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Lando Cermeans <u>Mamie Mae Messinger</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) law Anna Edwards - Daughter-in-2121 Sparrows Point Road Point.MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Baltimore MD MD cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 8-17-10 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 22. Name and Address of Facility Bradley-Ashton Funeral Home 21. Signature of Juneral Service Licensee <u>2134 Willow</u> Spring Road, 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) car Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) J physician and is the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 for use as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) Pregnant at time of death been signed by the should be detached 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed? Yes 2 N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Division of Vital Hospital: Other: 1 Tes 2 X No 4 Nursing Home 5 Residence 6 Other (Specify မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation after death Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after de To the Funeral Directo completed filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the beat of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my Knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 | To the P within 2 To the P only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed caus of death (Item 23a) (Type, P 0 31. Date filed (Month, Day, Year) 2. Registrar's Signature State AUG 1 6 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ AUCUST Esther E. Parkinson 03:55 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SAINT JISEPH MEDICAL CENTER TOWSON BALTIMORE 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2**X**🗆 F (Month, Day, 1920 169-14-9743 90 Director Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location items 23a or zoa-, c... 10d. Inside City Limits Director Baltimore Glen Arm MD 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21057 11630 Glen Arm Road 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Yes 2 X No Yes, Give Black, White, etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. white Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4 or 5+) 5 **+** Elementary/Seconday (0-12) Finance Accountant other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental H မ should be Hazel Barrett Wallace Remaley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1 and 2 st of Health a item 27 is 21093 Elisabeth Parkinson-daughter 5 Rhodes Place, Timonium, Maryland 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 a Department of H Important; If ite any injury or ot Date odd Fellows Cemetery Aug. 14, 2010 Tamaqua, Pennsylvania Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 ME Fadde ondrae 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Betweer Immediate Cause (Final Physician/ MASSIVE GASTROINTESTINAL BLEED disease or condition resulting in death) 2 HOKES Medical Examiner SECONDARY TO DUODENAL ULCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine NON STELEVATION MYOCARDIAL INFARCTION 3 DAYS Physician/Medical ACUTE PANCREATITIS S DAYS Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 month 1 Yes 2 No 9 Unknown 4 Pregnant at time of death
9 Unknown signed by the a Id be detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş RENAL FAILURE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy certificate 1 ☐ Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA ြုင 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 Natural 2 Accident 3 Suicide injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gentlying Nume Pranticion To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner at estated. (Check 29b. Signature and title of certifie

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Medical 4a. Facility Name (if not institution, give street and number) Ab. City, Town, or Location of Death **Examiner** 4c. County of Death dustington Melica 150 6 . Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Days 4 12 7 1 963 1 ☑ M 2 □ F Months California 92 9922 47 Director 214 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland the Medical Examiner must be notified at Director 1 🗌 Yes 2 🔀 No FLBroward Sunrise 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1572 East Wind Circle 33326 U.S.A. items 12. Was Decedent Ever in U.S.

Armed Forces?

1 ☑ Yes 2 ☐ No 1 984 
If Yes, Give 1 0 9 6 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. ō à 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural" Completed 3 ☐ Widowed 4 ☑ Divorced 1986 White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumation. Elementary/Seconday (0-12) 1 2 Quick Fuel College (1-4 or 5+) Truck Driver Fleet Services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence Douglas Parker Yvonne Marie Chrisikos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kelly Derflinger -8563 Bay Rd. sister Pasadena, 21122 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 

Burial 2 

Cremation 3 

Removal from State 4 Donation 5 Other (Specify) Bayview Crematory 8/13/10 Baltimore, 22. Name and Address of Facility GJ Gonce Funeral Home, 21. Signature of Funeral Service Licensee PA 21122 169 Riviera Dr. Pasadena, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of, attending physician and I for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No been signed by the atte should be detached for Pregnant at time of death Month Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ 3 ☐ Probably 4 ☐ Unknown Completed . Were autopsy findings available prior to completion of cause of 24a, Was an page 2 s autopsy perform death? 1 Yes 2 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ patient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed-(Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fh g906 8-16-10 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Miriam Elsie Phelps Aug 12, 2010 Year 5:55 A M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Ellicott City** Howard Ellicott City Health & Rehab Center 8. Date of Birth (Month, Day, Year) Jan 27, 1923 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Days Months 1 M 2 F Hours 213.20.5369 87 Country) Marylan Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Howard Ellicott Clty 1 Tes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 3685 Rogers Avenue 21043 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) maintenance canvas production 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lawrence I. Phelps Lillie Mae Fegan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Klein 3685 Rogers Avenue Ellicott City, MD 21043 20a. Method of Disposition UG<sup>Date</sup> 46, 2010 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Good Shepherd Cemetery Ellicott City, Maryland 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 21. Signature of Fuperal Service License Part 1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. Li only one cause on each line Immediate Cause (Final STAGE disease or condition resulting in death) DEMENTIA Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): ate of delivery /lonth Day Year ntribute to the cause of death? 3 Probably 4 Whiknown Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

Physician/ Medical Examiner

that the death certificate be executed

Hospital or Attending Physician: The law requires 24 hours after death.

After

Box 68760

P.O.

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Division of Vital

Physician/

Medical

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Funeral

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Examiner

**Funeral** 

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other thaumatic event, the Medical Examiner must be notified at any Injury or other thaumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Be Completed by Physician/Medical Examiner attending physician a for use as the buraled by the cate has been signed page 2 should be det To the Hospital or Attendinwithin 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur Medical

	Cause (Disease or Influry that initiated events resulting in death) Last	c	uence of):						_
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1  Live Birth 2  Feta 4  Pregnant at time of a 9  Unknown	al death 3 🗌 Ectopi	c pregnancy (specify)			23d. Date of de Month	elivery Day Ye	38
	Part II. Other significant conditions con	ntributing to death but not res	sulting in the underlyin	g cause given in Part I.	2	3e. Did tobacco us	se contribute to	o the cause of dea	a
	DM (DIAB					1 🗆 Yes 2	□No 3□F	Probably 4	ń
	PROBABLE CO	RONARY	ATHER	OSCLERO	5 ( ) 2	24a. Was an autopsy performed?	prior to death?	utopsy findings av completion of cau	
	25. Was case referred to medical			26. Place of Death (0	Check only	one)			
	examiner? 1 Yes 2 No	lospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4 Nursir	g Home 5	Residence 6	Other (Spec	cify)	
	27. Manner of Death Natural 5 Pending Accident Investigation		28b. Time of injury M	28c. Injury at work? 1 ☐ Yes 2 ☐ No	- 1	escribe how injury	occurred		
		6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number City or Town, State)			

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month. Day. Year)

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Certificate: To

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shakunmale 31. Date filed (Month, Day, Year)

SANTIAKO 9650

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ August 12 2010 8:50 PM William Louis Quinn Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE TOWSON GREATER BALTIMORE MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) A110 . 11 . 1951 Social Security Number . Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Mary Land **Director** 215-48-7062 59 Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Pinellas Florida Dunedin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? and Mental Hygiene. Is marked other than "natural", or items 23a or raumatic event, the Medical Examiner must be r Funeral 242 Garden Circle South 34698 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black. White, etc. JUINN, WILLAM by 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Investigation vears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked o any injuy or other traumatic eve once. ည Harry A. Quinn Mary Kraus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 242 Garden Circle South Dunedin, Florida 34698 Nona M. Quinn (wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 8-17-10 Green Mount Crematory Baltimore, Maryland 21. Signature of Funeral Service Licensee <sup>22, Name and Address of Facility</sup>
Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Road Baltimore, Maryland ellass 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Acute Physician/ Days disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, it cause. Enter Underlying Cause (Disease or iinjury ner Due to for as a consequence of Exami Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. for use as the burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Year Month Day Pregnant at time of death as been signed by the a should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Pneumine 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an las autopsy this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical the funeral director, 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Other: 1 Inpatient 2 ER/Outpatient 3 DOA Certificate; To 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 Natural 2 Accident injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) D26394 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. CHARLES ST A450 21204 6535 WECLEN 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 5:45 A M 2010 Anthony August 3 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Stella Maris Hospice Towson Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🌠 M 2 🗆 F Months Days Hours July 8. 1924 Director Maryland 86 <u>216-18-7300</u> Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Dundalk 1 Yes 2 Xio Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 1313 Delvale Avenue 21222 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian , or 1 Never Married 2 Married Completed by Yes, Give 21215-0036 1 ☐ Yes 2X No Specify: Specify: White "natural", 3 X Widowed 4 ☐ Divorced Year or Dates. any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 11 years Machanist Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anthony Rossi Carmella Yocco 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1313 Delvale Avenue, Dundalk, Maryland 21222 Patricia Critzman Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite August 16, cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Stanislaus Cem. Baltimore, Maryland 4 Donation 5 Other (Specify) 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 23a. Part 1. Enter the disease, complications that caused the death. Vo not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ LIVER CANCER disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to for as a nonsequence of; dany, leading to immediate cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Year Pregnant at time of death 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director, After completed filled in by the funer 1 X Natural 5 Pending Μ 1 Tyes 2 🗌 No Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check

State Registrar 29b. Signature and title

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2300 DULANEY VALLEY RD.

eson who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

3 🖫 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

TIMONIUM, MD 21093

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10gs16a of Maryland Department of Health and Mental Hygiene 25462 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Anthony John R. Russell-Wood 10:45 P M August 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 113 Belmore Road Lutherville Baltimore Social Security Numbe 7. Age (In yrs. 70 If Under 1 Year If Under 24 Hrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗓 M 2 🗆 F Months Days Hours 10/11/1939 Director 219-66-9375 England Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Mary land Baltimore Lutherville 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
United Kingdom Funeral 113 Belmore Road 21093 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces ģ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specify: White Completed Specify: 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working life. DO NOT use retired) American Professor Latin History History (Specify only highest grade completed) Johns Hopkins Elementary/Seconday (0-12) College (1-4 or 5+) University 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dr. James Russell-Wood Ethel Roberts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Hannelore Russell-Wood / Wife 113 Belmore Road Lutherville, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or o
once. cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hilltop Serv. Corp. 8/16/2010 Towson, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licen 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Texcest disease or condition me Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events attending physician and for use as the bunal-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical **Hospital or Attending Physician**: The law requires that the death certificate be 24 hours after death. Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy To the Funeral Director: After this certificate has been signed by the atter completed filled in by the funeral director, page 2 should be detached for i in the past 12 months? Dav Year 2 🗌 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 🗐 💢 o 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 Yes Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 20X No ၉ 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred Natural Natural (Month, Day, Year) injury 5 Pendina Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 3010 30. Name and address of person who comp ed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland ADepartment of Health and Mental Hydienes

		•	1 - For Amen State Registrar	d 166 208	per files	<b>906',08/1</b> '6 ertificate of l	<b>/2010ah</b> Death	b Wellai Hy	Reg. No.	2010	25463
	Physicia		Decedent's Name (First, Middle, La      Mary C. Raglan					2. Date of De Month July	ath 30	2010	3. Time of Death 12:50 PM
	Medic Examir		4a. Facility Name (if not institution, give	4b. City, Town, or Location of Death			4c.	4c. County of Death			
	Funeral		St. Thomas More  5. Social Security Number 6. S	If Under 1 Year	If Under 1 Year			Prince George's  9. Birthplace (State or Foreign			
	Director	To Be Completed by Funeral Director	221-14-1409 13 1 221-14-1409 14 1 221-14-1409	□ M 2 <b>X</b> F	83 Yrs.	Months Days	Hours M	lin. (Month, Da April	15 19	927 Geo	rgia
	72 hours after death with the Maryland "natural", or items 23a or 28a-f show ledical Examiner must be notified at		10a. State 10b. County 10c. City, Town or Locat								10d. Inside City Limits
			DC  10e. Street and Number		Washin	10f. Zip Code			10a Citi:	zen of What Cou	1 X Yes 2 □ No
			3001 Bladensburg	Rd., NE	<i>‡</i> 707	20018	3		rog. o	USA	
21215-0036			11. Marital Status  1  Never Married 2  Married 3  Widowed 4 Divorced	12. Was Decedent Ender Armed Forces?  1 Tares 2 1 If Yes, Give Year or Dates.		Was Decedent of H If Yes, specify Cuba 1 Yes 2 No		(Specify Yes or No- erto Rican, etc.)		14. Race - Americ Black, White, Specify: Bla	etc.
215-(	172 ho an "nat Medica		15. Decedent's E (Specify only highest gr	ade completed)	(Give	edent's Usual Occup e kind of work done o DO NOT use retired)	ation during most of w	vorking	16b. Kir	nd of Business In	dustry
	d withir lygiene ther tha		Elementary/Seconday (0-12)	College (1-4 or 5- 4	+)	ecretary					overnment
Maryland	ge 1 and 2 should be filed within 72 hours aft nt of Health and Mental Hygiene. : If item 27 is marked other than "natural", or other traumatic event, the Medical Exar		17. Father's Name (First, Middle, Last)  Elick Crawford					Name <i>(First, Middle,</i> Lena Wil	Maiden S cocks		
Aary	should and M is mai		19a. Informant's Name/Relationship (7			ling Address (Street					Code)
	and 2 s Health tem 27		Marsha George Bi	ssoon / Nie		Sheriff I		Date unk		20785	own, State unlt
Baltimore,	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	fy)	cemetery, cre	ematory or other place	re)		Br	entwood,	MD
Bal	permit Depart Import any inj once.		21. Signature of Funeral Service (Cens	(CL)		22. Name and Address B401 Blade					ome 0722
	Physician/ Medical		23a. Fart 1. Enter the discrete, or come shock, or heart fail received is to only of disease or condition resulting in death)	ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest cause on each line.  ASCVD  Due to (or as a consequence of):					Approximate Interval Between Onset and Death		
	Examiner	miner	Sequentially list conditions.	er							
	ed sit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to (or as a	Due to (or as a consequence of):						
	execui ian and irial-tra	I Exa	that initiated events resulting in death) Last	Due to (or as a	to (or as a consequence of):						
8760		Completed by Physician/Medical Examiner		d							
Box 687			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome o 1  Live Birth 2 4  Pregnant at 9  Unknown	Fetal death 3	☐ Ectopic pregnand ☐ Other (specify)	у		2	23d. Date of deliv Month	ery Day Year
P.O.	es that the des signed by the s be detached t	by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of de								
ords	v require s been si should k	eted	HTN, Pancreatic cancer, Colon cancer								
of Vital Records,	The law ate has I page 2 s	Somp						24a, Was autop perfo 1 ☐ Yes	osy rmed?	prior to co death?	psy findings available mpletion of cause of 2 \square No
ital	s <b>iclan:</b> The la certificate harector, page	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2IX No	Hospital:		Oth	ace of Death (Cl				
	ding Phys th. After this funeral di	Certificate: To	27. Manner of Death  1 ☑ Natural 5 ☐ Pending	1 ∐ Inpatier  28a. Date of injury (Month, Day,	nt 2 ER/Outpatie  / 28b. Time of injury	ent 3 🗆 DOA	4 🔼 Nursing / at	Home 5 Resid			)
Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completed filled in by the fun		2 Accident Investigation 3 Suicide 6 Could not b			M 1 🗆	Yes 2 No	206	\	Alcomban an Brown	Davida Mumbar
Divi		Cer	4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)			City or Town, S				at and Number or Rural Route Number, State)	
		Medical	29a. Certifier (Check only one)  1								
	To the within 2 To the comple		29b. Signature and title of certifier	1		29c. License				signed (Month,	
	5		30. Name and address of person who	ompleted cause of dea		Print)	er Sprin		0904	1	
	Stat Registra	-	Dr. Ajit Kurup 31. Date filed (Month, Day, Year)  AUG 1 6 2010	32. Registrar			r obrri	-0, 1.0 2			
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 14, August 2010 10:50 AMM Riddleberger Margaret Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore **Essex** Riverview Care Center Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🏻 F Months Days Hours Min. 1/23/1929 Maryland Director 215-24-4766 81 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Baltimore Maryland Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21220 S. A. 919 Susquehana Avenue death 1 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or by 1 Never Married 2 Married 72 hours after Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Completed 3 X Widowed 4 ☐ Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygelen. Important. If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Baier Goeller Mary George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Daughter <u>Dianne Riddleberger</u> Essex, Maryland 21221 <u>2112 Riverview Road</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 2618 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Memorial Gardens Middle River, Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue 21. Signature of Funeral Service Licenses Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between SCVD Onset and Death Immediate Cause (Final Pnysician disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate the Fried Ut drying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami the Hospital or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) physician at the burial-Physician/Medical Box 68760 signed by the attending p d be detached for use as: IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Junknown Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t director, page 2 s performed? Yes 2 X No 2 🗌 No 1 Yes **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 2**X** No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 Pending 1 Tes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1
2 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my opinion death accurately and the cause (s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mpleted cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

State Registrar Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Day Physician 8, 2010 4:00 P.M August Mian Shallwood /Medical 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner N/ABaltimore FutureCare Canton Harbor If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplece (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Hours Months 1 □ M 2 🖾 F 75 7-19-1935 Director 240-68-3138 N.Carolina Usuel Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. Stete 10b. County r than "naturel", or items 23e or 28e-f show the Medical Examiner must be notified at N/A MX es 2 □ No MD Baltimore Funeral Director 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 3310 Lake Avenue 21213 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ZX No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: Specify: Black þ 3 Widowed 4 ☐ Divorced Be Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home unknown other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) it of Haalth and Mental Pages 1 and 2 should be Charley Williams, Sr. Susie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Donald L. Smallwood/Grandson 3310 Lake Avenue Baltimore, MD 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department or Important: If any injury or 8/13/10 Baltimore, MD Greenmount Cemetery 4 Donetion 5 Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral 21. Signature of Funeral Service Licensee 4210 Belair Road Baltimore, MD 21206 ullen 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in deeth) years bonouta Examiner Due to (or as a consequence of) Examiner or Attanding Physician: The law raquiras that the death certificata be axecuted the burial-transit Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physiclan/Medical Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Acterio stensile Cornary Actor Dream 3 Probably 4 Unkhown 1 ☐ Yee 2 ☐ No 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed Centrominean y dale tes 2 1100 1 ☐ Yes 2 ☐ No 1 ☐ Yes eral Director: After this cartific filled in by the funeral diractor, 25. Wes case referred to medical examiner? Be 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: Medical Certification: To 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled To the Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner steted. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier war fed D19667 08-13-2010 Clear 30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print) Ritchie Highway \$ 508. Gleu Brien Hayland 2061 aus 2020107310 tiquel 31. Dete filed (Month, Day, Year) 32. Registrar's signature State AUG 1 6 2010 Registrar

DHMH 16 Rev 6/95

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 2010 ar Physician Sudano 14, 5:00 p M Michael George Aug. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 21 Fuller Avenue If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 216-32-7159 75 Director 4-25-35 Maryland Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 🕅 No Director Md. Baltimore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 21206 21 Fuller Avenue U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ∏Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 Z¥No 2 Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wit Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumaste. City of Baltimore Transporter 8th 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be Impallaria Sebastiano Sudano Gicamina ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melinda L. Sudano - Wife 21 Fuller Avenue Baltimore, Maryland 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 8-19-2010 Baltimore, Maryland OakLawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph N. Zannino Jr. F.H. 21. Signature of Funeral Service Linenses Conkling Street Balto. Md. 21224 263 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart tailure. List only one cause the close the death. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed and burial-trar Box 68760. physician Physician/Medical the as attending IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 1 ☐Yes 2 ☐No the 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? cate has t page 2 s autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes ₽ ☐ Ne Division of Vital To the Hospital or Attending Physician: After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 4 Residence 6 Other (Specify) 1 | Yes | 2 | □ | 1 Innatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred **U**HNatural 5 Pending ithin 24 hours after death.

the Funeral Director: A

ompletely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🖅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 29b. Signature 29d. Date signed (Month. Dav. Year) hd title of certifier 29c. License numbe completed cause of death (Item 23a) (Type/ Print) 30. Name and address of person who come V 32 Registrar's Signature 31. Date filed (Month. Day. Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Howard Russell Simpson August 20Î0 8:02 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Gilchrist Baltimore Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** Days 1 🛛 M 2 □ F Jan 17, Year) 927 Months Hours New Jersey 007-22-8401 Director 83 Usual Residence of Decedent ני זו זופח 27 וs marked other than "natural", or items 23a or 28a-f shov or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director N/A Baltimore Md. 1 X Yes 2 No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Completed by Funeral 1018 W. St. Georges Rd. 21210 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Investment Banker Banking 4 Hygier other t Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Edward Simpson Mildred Apgar Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Katherine Simpson/ Wife 1018 W. St. Georges St. Baltimore, Md. 21210 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, Burial 2 ☐ Cremation 3 ☐ Removal from State Evergreen Cemetery 8-16-10 Hillside, NJ 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. Signature of Funeral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onser and Death Immediate Cause (Final Physician Medical resulting in death) Tue to (or as a consequence of) **Examiner** Sequentially list conditions, rany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Ducito for as a consequence on or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day Year 1 Yes 2 L g Unknown g Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Yes 2 🕽 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 Yes 2 [ Yes 25. Was case referred, to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Dew Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending 1 Yes 2 🗌 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Yea

8:02

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 201<sup>Year</sup> August Presanna 8:35 Sivan Αм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 26 Westspring Way Lutherville 8. Date of Birth (Month, Day, Dec. 23 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) 1 □ M 2 🛣 F Days Hours Director 382-76-7511 60 De'c\_ 949 India ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🙀 No Baltimore MD Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 26 Westspring Way USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-14 Race - American Indian Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 X Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Indian Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bhaskaran Poyilkandy Lakshmi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valaparambil Sivan / husband 26 Westspring Way; Lutherville, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 💆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Hilltop Service Corp. 8/16/2010 4 ☐ Donation 5 ☐ Other (Specify) Towson, MD 21. Signature of Funeral 22. Name and Address of Facility 1050 York Road Inc. Towson, MD 21204 Ruck Towson Funeral Home, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final husician/ YOCARDIAL INFARCTION disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner HYPO+ Sequentially list conditions, if any head got in mediat cause. Enter Underlying Cause (Disease or iinjury Examiner Directo for as a consecuence of signed by the attending physician and d be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Dav Year 1 Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ACCIDENT RIRDIO VAS Cular 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t lirector, page 2 s autopsy performed? Yes 2 ☐ No 24 hours after death.

Funeral Director: After this certificeted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🖪 No Other: 횬 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 27, Manner of Death 28c. Injury at work? Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier critifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completed file Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD AUG 55306 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 200 9106 PHILADEPHIA ENNIS H. OPIE MD

JDHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

AUG 1 6 2010

arks

32. Registra 's Signature

10-06087

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Richard \	William		n S I- For State	tate of Maryla		artment of rtificate of		nd Mental	Hygiene			
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	l Exami	.11.7		illiam St	em				Month Augu	st 14, 2	Day Year 2010	1014 hrs
,			4a. Facility Name (if not instituti	-	mber)		4b. City, Town, o Westminst		eath		4c. County of De	eath
_	1		Carroll Hospital Cent  5. Social Security Number		7. Age (In yrs. la	ast birthday)	If Under 1 Ye		4Hrs. 8. Date	of Birth		Birthplace (State or
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	any		10a. State 10b. County		10c. City,	Town or Locat	ion					10d, Inside City Limits
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Many	tn tne Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number				10f. Zip Code			10g	g. Citizen of What C	Country?
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4	or items	Funeral	11. Marital Status 1 Never Married 2 X	Married Armed Fo			es, specify Cuba				White, et	
Ber de	l", or		3 Widowed 4 D	1 Yes vorced If Yes, Give Year or Dates:		1	Yes 2X N	o specify:			Specify:	White
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00	giene.	Completed	17, Father's Name (First, Middle	e, Last)		IIIdes	- DIIVEI		lame (First, Mi	ddle, Ma	aiden Surname)	bearr, rice.
215 E	uid be filed within 72 hours after Mental Hygiene. marked other than "natural", c event, the Medical Examiner.	BeC	Aubrey Josep					Edith	n (Cas	e)		
Baltimore, MD 21215-0036	hould to nd Mer is mar	2	19a. Informant's Name/Relation Sharon E. Ste								er, City or Town, S	itate, Zip Code) 21797
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		iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a	consequence o	of):						
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O. B	that the death certificate ned by the attending phy detached for use as the b	Phy	Part II. Other significant cond		_	resulting in the t	underlying cause	given in Part I	. 23e	. Did tob	pacco use contribut	e to the cause of death?
Э.	ures that the signed by ' d be detach	d by							1	<b>✓</b> Yes	2 No 3	Probably 4 Unknown
rds	law requir has been si e 2 should b	Completed						_	24a	. Was ar autops	y prior	e autopsy findings available r to completion of cause of
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Ĭ.	Physic r this al dire	To E	1 ✓ Yes 2 No			ER/Outpatient		Other <sub>4</sub> N	lursing Home		Residence 6 (	Other:
Division of Vital Records,	nding Ph h. : After t e funeral	• •	27. Manner of Death 1 ✓ Natural 5 Pe	28a. Date (Month,	Day,Year)	Zob. Time of		Yes 2 N		SCI IDE TI	ow injury occurred	
isio	r Atter er deat rector i by th	icat	2 Accident Inv	estigation	e of Injury - At h	nome, farm, stre	et, factory, office	building, etc.				or Rural Route Number, City
i i	ipital or Attend ours after death reral Director: filled in by the	Certification		ermined (Specify)					or I	own, Sta	ate) 	
Ė	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death, within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b		(Critical Critis)	Physician: To the bestaminer: On the basis of	t of my knowled	dge, death occu	rred at the time,	date and place	e, and due to the	ne cause e. date a	e(s) and manner as	stated. to the cause(s)
	Te th withi Te th comp	Medical	one) 2 ✓ Medical Ex 29b, Signature and title of certi	and manner st				nse number		1		(Month, Day, Year)
			D. AR.	1/1/11				.M.E.			August 15, 20	010
	0,		30. Name and address of person	on who completed caus	se of death (Item							
	1		Pamela E. Southall,	MD Assistant I	Medical Exa	aminer 11	11 Penn Stre	et, Baltimo	re, MD 212	201		
	S	tate	31. Date filed (Month, Day Yea	32. Re	gistrar's Signat	ure face	d					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Esther Strickland 2021 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Balkmore Cit NA If Under 1 Year If Under 24 Hrs. Social Security Number **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Birtny Country MD 1 □ M 2 🛛 F Min. 09-28-59 Hours 220-90-692 50 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD NA 1XXYes 2 No Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4834 Beaufont Avenue 21215 USA Shickland, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etcAfrican þ 1X Never Married 2 ☐ Married Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: American Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10th Grade Housekeeping NA Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file. and Mental H is marked ot <u>Annie Mae Lucille Hughes</u> Muriel Fountain 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23015 19a. Informant's Name/Relationship (Type, Print) Doris Saunders-Cousin 12416 New Market Mill Road Beaverdam, VA Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗀 Burial 2 XCremation 3 🗆 Removal from State Metro Crematory 08-16-10 Catonsville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licenses 638 N. Gilmor Street Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ Brebal disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner tomorrhas Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a conseque e of) that the death certificate be executed Due to (of as a consequence of): that initiated events resulting in death) Last attending physician a I for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Pregnant at time of death Yes 2 No ate has been signed by the page 2 should be detached 9 Unknown 9 🗍 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? ð Hospital or Attending Physician: The law requires 2 No of Vital Records, 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 X No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No ပ Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Division Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier August 10, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tomich Balkmore 2401 W. Reliactore Aro. 31. Date filed (Month, Day, Year) -32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

1 - For State Registrar

29a. Certifier (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)
AUG 1 6 2010

**Physician** 

/Medical

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If itam 27 ta marked other than "natural", or Items 23a or 28a-f ahow any injury or other traumatic avent, Ita Mccleal Examiner must be notified at

Physician

To Be Completed by Funeral Director

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107. Zp Code  109. Citizen of What Country?  21009  USA  Americal Status  1   Was Decedent Education   13, Was Decedent of Hispanic Origin? (Seach) Yes or No- 11   Wever Married 2   2   2   2   2   2   2   2   2   2	MD HARFORD	HARFORD								
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Computer Scientist   Scienti			16a.	Deced (Give	tent's Usual Occupa kind of work done	ation during most of work	ring	16b. Kin	d of Busines	ss/Industry
Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maiden Sumame)		College (1-4or 5+)							NSA	
### ATLANTIC REBECCA IONES  9a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  3 DANNE SCHWABLINE  3 Serwick CT., ABINGDON, MD 21009  20c. Location - City or Town, State and Number of Rural Route Number, City or Town, State and Number, City or Town, State and Number, City or Town, State and Number, City or Town, State and Number, City or Town, State and Number, City or Town, State and Number, City or Town, State and Number, City or Town, State and Number, City or Town, State and Number, City or Town, State and Number, City or Town, State and Number, City or Town, State and Number, City or Town, State and Number, City or Town, State and Number, City or Town, State and Number, City or Town, State and Number, City or Town, State and Number, City or Town, State and Number, City or Town, State And Number, City or		4			J OILK 001		e (First, Middle.	Maiden S		
19b. Mailing Address (Street and Number or Alval Route Number, City or Town, State, Zip Code)   30ANNE SCHWABLINE									,	
ADDAINE SCHWABLINE WIFE  A. Mathod of Disposition  1   Burial 2   Cremation 3   Removal from State  4   Density S   Other (Special Answer)  FINK FUNERAL HOME, P.A.  K. GREGOY FINK  MO1148   425 CRAIN HWY. S., GLEN BURNIE, MD 21061  3   Part I Ever the disposition of the disposit		voe. Print)	19b	Mailin	ng Address (Street a				Town. State	a. Zin Code)
All was a a sortered to medical examiner?   All continuers   All continu										-,,
Less. Enter Underlying use (Disease of Injury at Indiated events stulling in death) Last  C. Due to (or as a consequence of):  d.     Due to (or as a consequence of):	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	20b. Place of cemeter	Dispo cren CRI	sition <i>(Name of</i> natory or other plac EMATORY INC	θ)   AUG.	9, 2010	20c. Loc		
FEMALE: b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  TII. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23d. Date of delivery Month Day Year  23d. Date of delivery Month Day Year  1   Live birth 2   Fetal death 5   Other (specify)   9   Unknown  1   Yes 2   No 3   Probably 4   Unknown  24a. Was an autopsy performed? 1   Yes 2   No 3   Probably 4   Unknown  24b. Were autopsy findings availa prior to completion of cause of death? 1   Yes 2   No 2   No 2   Yes 2   No 2   Yes 2   No 2   Yes 2   No 2   Yes 2   Y	1 Burial 2 Cremation 3 Communication 5 Communi	FINK M cations that caused the e cause on each line.	20b. Place of cameter BAYVIE	Dispondice of CRI 222 F 42 not enter	sition (Name of natory or other place EMATORY INC.)  Name and Address INK FUNERAL ACT OF THE MODE OF T	AUG. ss of Facility HOME, P.A. Y. S. 2 GLEN g, such as cardiac	9, 2010 BURNIE, or respiratory arr	20c. Loc BALT MD 2	IMORE,	Approximate Interval Between
23c. If yes, outcome of pregnancy in the past 12 months? 1   Live birth 2   Fetal death 3   Ectopic pregnancy   1   Live birth 2   Fetal death 4   Pregnant at time of death 9   Unknown   2   No 9	1 Burial 2 Cremation 3 14 Donation 5 Other (Specify  1. Signature of the Care	FINK M  I cations that caused the e cause on each line.  Due to (or as a control of the control	20b. Place of cameter BAYVIE	Dispondent CRI  222 F  43 not enter	sition (Name of natory or other place EMATORY INC.)  Name and Address INK FUNERAL ACT OF THE MODE OF T	AUG. ss of Facility HOME, P.A. Y. S. 2 GLEN g, such as cardiac	9, 2010 BURNIE, or respiratory arr	20c. Loc BALT MD 2	IMORE,	Approximate Interval Between
1   Yes 2   No 3   Probably 4   Unkno 2   24a. Was an autopsy performed? 1   Yes 2   No 3   Probably 4   Unkno 2   24b. Were autopsy findings availa prior to completion of cause of death? 1   Yes 2   No 1   Yes 2   No 2	1 Burial 2 Cremation 3 1 4 Donation 5 Other (Specify  1. Signature of the dispassion of the shock, or part failure of the season	Removal from State  FINK  M  cations that caused the cause on each line.  a.  Due to (or as a continuo)	BAYVIE  011148 9 death. Do n	Dispo Crent CRI 22 F 1 42 not entr	sition (Name of natory or other place EMATORY INC.)  Name and Address INK FUNERAL ACT OF THE MODE OF T	AUG. ss of Facility HOME, P.A. Y. S. 2 GLEN g, such as cardiac	9, 2010 BURNIE, or respiratory arr	20c. Loc BALT MD 2	IMORE,	Approximate Interval Between
24a. Was an autopsy performed?    24a. Was an autopsy performed?   24b. Were autopsy findings availal prior to completion of cause death?   1   yes 2   No   1   yes 2   yes 2   No   1   yes 2   1 Burial 2 Cremation 3   4 Donation 5 Other (Specify  1. Signature of the disease or commodate Cause, Final sease or conditions, any, heading to inclined the use. Enter Underlying aus of Disease or conditions, any, heading to inclined the use. Enter Underlying aus of Disease or conditions, and the use of th	Removal from State  FINK  M Cations that caused the e cause on each line.  a. Due to (or as a complete to the	BAYVIE  011148  e death. Do n  onsequence of  onsequence of  pregnancy  Fetal death	Dispo	sition (Name of natory or other place EMATORY INC Name and Addres INK FUNERAL 26 CKAIN HW er the mode of dyin	AUG. ss of Facility HOME, P.A. Y. S. 2 GLEN g, such as cardiac	9, 2010 BURNIE, or respiratory arr	BALT MD 2 est,	1061  3d. Date of	Approximate Interval Between Onset and Death	
was case referred to medical examiner?    Was case referred to medical examiner?   Hospital: 1   Inpatient   2   ER/Outpatient   3   DOA   Other: 4   Nursing Home   5   Residence   6   Other (Specify)   Hotel   1   Nursing Home   5   Residence   6   Other (Specify)   Hotel   1   Nursing Home   5   Residence   6   Other (Specify)   Hotel   1   Nursing Home   5   Residence   6   Other (Specify)   Hotel   1   Nursing Home   5   Residence   6   Other (Specify)   Hotel   1   Nursing Home   1   Nursing Home   28d. Describe how injury occurred	1 Burial 2 Cremation 3 Care Constitution 1 Care Constitution 2 Car	Removal from State  FINK  I cations that caused the e cause on each line.  Due to (or as a complete to the com	D1148 e death. Do nonsequence of consequence of con	Dispo	sition (Name of natory or other place EMATORY INC.)  Name and Address INK FUNERAL 26 CRAIN HW er the mode of dyin Carlon Communication of the mode of the carlon Ca	AUG. So of Facility HOME, P.A. Y. S., GLEN g, such as cardiac	9, 2010  BURNIE, or respiratory arr	BALT MD 2 est,	1061  3d. Date of Month	Approximate Interval Between Onset and Death O
Was case referred to medical examiner?    Manner of Death	1 Burial 2 Cremation 3   4 Donation 5 Other (Specify  1. Signetr 5 Cure 1  3. Rart1. En er the dispass or commendate Cause (Final sease or conditions sulting in death)  sequentially list conditions, any, reading to include the cause (Disease or injury at initiated events sulting in death)  FEMALE:  B. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	Removal from State  FINK  I cations that caused the e cause on each line.  Due to (or as a complete to the com	D1148 e death. Do nonsequence of consequence of con	Dispo	sition (Name of natory or other place EMATORY INC.)  Name and Address INK FUNERAL 26 CRAIN HW er the mode of dyin Carlon Communication of the mode of the carlon Ca	AUG. So of Facility HOME, P.A. Y. S., GLEN g, such as cardiac	Date  9, 2010  I BURNIE, or respiratory arr	BALT MD 2 est,	1061  3d. Date of Month	Approximate Interval Between Onset and Death Onset and Death
Manner of Death   Manner of Death   Natural   S   Pending investigation   Massing Home   S   Residence   Gamma   State of Injury   State	1 Burial 2 Cremation 3  4 Donation 5 Other (Specific Line)  K. GREGORY  Ba. Part1. En er the dispass or coming shock, or part failure at only of mediate Causs. (Final sease or conditions, any, reading to inchediate Line (Boston of Common  Removal from State  FINK  I cations that caused the e cause on each line.  Due to (or as a complete to the com	D1148 e death. Do nonsequence of consequence of con	Dispo	sition (Name of natory or other place EMATORY INC.)  Name and Address INK FUNERAL 26 CRAIN HW er the mode of dyin Carlon Communication of the mode of the carlon Ca	AUG. So of Facility HOME, P.A. Y. S., GLEN g, such as cardiac	23e. Did to 1 Y 24a. Was a autoppendor	BALT MD 2 est,  2: bacco uses 2 □	3d. Date of Month  See contribute  No 3   24b. Were prior:	Approximate Interval Between Onset and Death O	
2 Accident investigation August 5.2010 1112 A M 1 Yes 2 No Inticted aux 5 not wown 3 Suicide 6 Could not be	1 Burial 2 Cremation 3  4 Donation 5 Other (Specification 1) 1. Signature of the Common of the Commo	Removal from State  FINK  I cations that caused the e cause on each line.  Due to (or as a complete to the com	D1148 e death. Do nonsequence of consequence of con	Dispo	sition (Name of natory or other place EMATORY INC.)  Name and Address INK FUNERAL 26 CRAIN HW er the mode of dyin Carlon Communication of the mode of the carlon Ca	AUG. So of Facility HOME, P.A. Y. S., GLEN g, such as cardiac	23e. Did to 1 Yes	BALT MD 2 est,  2: bacco us es 2 [ in med? 2) No	3d. Date of Month  See contribute  No 3   24b. Were prior:	Approximate Interval Between Onset and Death O
28e. Flace of Injury - At home, farm, street, factory, office building, etc. (Specify)  28e. Flace of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street And Number or Rural Route Number, City or Town, State) 216 Excession (Street And Number or Rural Route Number, City or Town, State) 216 Excession (Street And Number or Rural Route Number, City or Town, State) 216 Excession (Street And Number or Rural Route Number, City or Town, State) 216 Excession (Street And Number or Rural Route Number, City or Town, State) 216 Excession (Street And Number or Rural Route Number, City or Town, State) 216 Excession (Street And Number or Rural Route Number, City or Town, State) 216 Excession (Street And Number or Rural Route Number, City or Town, State) 216 Excession (Street And Number or Rural Route Number, City or Town, State) 216 Excession (Street And Number or Rural Route Number, City or Town, State) 216 Excession (Street And Number or Rural Route Number, City or Town, State) 216 Excession (Street And Number or Rural Route Number, City or Town, State) 216 Excession (Street And Number or Rural Route Number, City or Town, State) 216 Excession (Street And Number or Rural Route Number, City or Town, State) 216 Excession (Street And Number or Rural Route Number, City or Town, State) 216 Excession (Street And Number or Rural Route Number, City or Town, State) 216 Excession (Street And Number or Rural Route Number or Rural Ro	1 Burial 2 Cremation 3 Comments of Comment	FINK  Cations that caused the cause on each line.  Due to (or as a complete to the complete to	20b. Place of cameter BAYVIE D11148 e death. Do nonsequence of consequence of con	ADispo	sition (Name of natory or other place EMATORY INC.  Name and Address INK FUNERAL 26 CRAIN HW er the mode of dyin Charles (Specify)	AUG. So of Facility HOME, P.A. Y. S. 2 GLEN g, such as cardiac  Aug.  an in Part I.	23e. Did to 1 Yes  th (Check only or	BALT MD 2 est,  2: bacco us es 2 C in sy med? 22No ine)	3d. Date of Month  se contribute No 3   24b. Were prior death	Approximate Interval Between Onset and Death O

29c. License number

bleHill CT. Lutherville, MDZ1093

29d. Date signed (Month, Day, Year)

August 6,2010

/Medical Examiner Division of Vital Records, P.O. Box 68760, To the Hospital or Attanding Physician: The law requires that the death certificate be executed the attending physician and thed for use as the burial-transit been signed by the atter should be detached for i filled in by the funeral director, page 2 After this within 24 hours after death.

To tha Funaral Diractor: A completely filled in by the fu

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

DHMH 17 Rev 1/2001

32. Registrar

			f - For State Registrar	State of Mar		rtificate of E		-	giene <sup>.</sup> Reg. No.		
	Physicia	ın/	1. Decedent's Name (First, Middle, Las	•	Coh			2. Date of De		Year	3. Time of Death
	Medic Examin	cal	4a. Facility Name (if not institution, give	Mary Dolo	ores scn	rauder  4b. City, Town, or	Leastien of Des	08	09	2010	2:30 Рм
	Examili	ier	Riverview Nursi			Esse		ıuı	4c.	County of Death	
	Funeral		5. Social Security Number 6. S	ex 7. Age (1	In yrs. last birthday)	If Under 1 Year	If Under 24 Hr	S. 8. Date of Bir	th	0 Birth	ore Co.
	Director		212-26-9141	□ M 2X F 8	1 Yrs.	Months Days	Hours Mir	(Month, Da Feb. 1	y, Year) 5,192	29 Mar	yland
	nd how at	٦	Usual Residence of Decedent  10a. State 10b. County	1	Oc. City, Town or Lo	ocation					I0d. Inside City Limits
	laryla 3a-f s ified	Director	MD Balt:	imore	•	D11	nda1k				1 ☐ Yes 2 ဩtNo
	or 28		10e. Street and Number	tmore		10f. Zip Code	iluaik		10g. Citi:	zen of What Cour	ntry?
	s 23a	Funeral	7902 St. Gregor	cy Drive		21222			Uni	ited Sta	tes
•	death ritem ner n		11. Marital Status	12. Was Decedent Eve Armed Forces?		Was Decedent of Hi If Yes, specify Cuba	spanic Origin? ( n, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	1	14. Race - Americ Black, White,	
36	after al", or xami	d by	1 ☐ Never Married 2 ☐ Married  3 ★ ★ Widowed 4 ☐ Divorced	1 Yes 2 No		1 ☐ Yes 2 ☒ No	Specify:		8	Spacific	White
9	hours natura ical E	Completed	15. Decedent's E		16a. Dece	dent's Usual Occupa	ation		16b. Kir	nd of Business Inc	
21215-0036	in 72 e. nan "ı	п	(Specify only highest gr. Elementary/Seconday (0-12)	ade completed)  College (1-4 or 5+)	(Give	kind of work done d OO NOT use retired)	uring most of w	orking			,
7	d with ygien her tl	Be C	8 Years		H	omemaker				m Home	
and	ntal H red ol	70 B	17. Father's Name (First, Middle, Last)  Joseph P. Rei	nsfelder				ame <i>(First, Middle,</i> 1 J. Smit		Surname)	
Maryland	should be file h and Mental H 7 is marked o raumatic eve		19a. Informant's Name/Relationship (7		10h Mail	ing Address (Street a	and Number or F	Pural Pouta Numba	r City or i	Town State 7in (	Cade)
Š	d 2 sh alth ar 27 is ir trau		Kathleen Kessel (			7 St. Gre				Marylan	
ore,	of Hear of Hear fitem		20a Method of Disposition	15 1/ 01	20b. Place of Disp		1	Date	20c. Lo	cation - City or To	own, State
<u>Ħ</u>	Page ment ant: It		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special			Service Co		2/2010	Tow	son, Mar	ryland
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.		21. Cignatury of Funeral Service Cens	iee)		2. Name and Addres Juda-Ruck 7922 Wise	Funeral	Home of	Dur	ndalk, I	nc. 1222
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only o	plications that caused th						Tand Zi	Approximate
~ F	Physician/		Immediate Cause (Final disease or condition		adiana	Imanas	M A	mest.			Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a co		1 - 1		mest. Lise ese			
		er	Sequentially list conditions,	b. Ather	MICHE	Hic he	art c	use ase	-		
Q.	ed Isit	Examiner	Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or linjury	Hypert						- 1	
2h .	n and al-tra		that initiated events resulting in death) Last	Due to (or as a co							
Ö.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical		l d	nestens	ر مها					
8760	tificat ing ph	Mec	IF FEMALE:		31						
Box 6	eath certifica attending p I for use as t	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p 1 Live Birth 2 Live Birth 2 Pregnant at tir	Fetal death 3	Ectopic pregnancy	4		2	3d. Date of delive Month	ery Day Year
ă.	the a	ysic	1 Yes 2 No 9 Unknown	9 Unknown	me or death 5 t	Other (specify)					
P.O.	that th	y Pt	Part II. Other significant conditions of	1		underlying cause give	en in Part I.	23e. Did to	bacco us	se contribute to th	ne cause of death?
Ś.	luires an sign uld be	ed b	(erebrovanci	na acc	is dent			1 🗆 '	Yes 2	☐ No 3 ☐ Prob	oably 4 Unknown
Ö	aw rec as bee 2 sho	plet						24a. Was a			osy findings available mpletion of cause of
Division of Vital Records,	The law cate has page 2 t	Completed by						perfo	rmed?	death?	
ta .	cian: ertific ector,	Be	25. Was case referred to medical examiner?	Hospital:			ce of Death (Ch	eck only one)			
<b>S</b>	Physi this c	. To	1 Yes 2 No  27, Manner of Death	1 Inpatient 28a. Date of injury	2 ER/Outpatie	nt 3 DOA Othe	4 Nursing	Home 5 Resid			)
ב ס	ding th. After funer	cate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Y		work'		28d. Describe h	ow injury	occurred	
Sio	Atter	Certificate:	3 Suicide 6 Could not b	e 28e. Place of Injury	- At home, farm, str					Number or Rural	Route Number,
<u>≥</u>	talor rsafte al Dira ed in l			building, etc. (5	Specify)			City or Tow	n, State)		
	4 hour	Medical	29a. Certifier 1 Certifying Physical Check 2 Medical Exami	sician: To the best of my iner: On the basis of exan	knowledge, death	occured at the time,	date and place,	and due to the cau	use(s) and	I manner as state	d. use(s) and manner stated.
	the lithin 2 the lomble	Ā	29b. Signature and title of certifier	se Prantioner: To the bes	st of my knowledge.	29c, License	time, date and p	lace, and due to the	cause(s)	and warrier as sta	Med
	2 3 2 8		PL 8	10/10 M	(.D.		6954		290. Date	signed (Month, L	-
	_	0 3	30. Name and address of person who o	completed cause of deat		Print)					21236
	8		Shah Jigan &	413 Walk	ham W	crds 2c	ل كاسا	to 204	Pa	1km/11e	2 MD
	Stat Registra	~	31. Date filed (Month, Dly, Year)	3. Registrar's	Signature	uli					

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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 25474 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 2010 B. Schultheis Doris 2:10 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Baltimore Co. Dundalk 812 Jeannette Avenue 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, <u>D</u>ay, Country) Maryland 219-18-5904 86 Director May Usual Residence of Decedent show 10a. State ms 23a or 28a-f shomust be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 812 Jeannette Avenue 21222 United States items 2 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces?

1 Yes 2 X No Black, White, etc. ō ģ 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. "natural", Specify: Completed 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Years Secretary Clerical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fisherships is marked or ပ Joseph Stultz Helen Stiegler permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. traumatic 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Barbara L. Schultheis 7453 Lawrence Road Dundalk, Maryland 21222 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 KCremation 3 Removal from State cemetery, crematory or other place Hilltop Service Corp. 8/13/2010 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licens 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition Due to (or as a consequence of) Medical resulting in death) Examiner 2mont Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of: Exami physician and the burial-transit resulting in death) Last Due to (or as a consequence of). Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death signed by the a d be detached for Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page 2 No 1 Yes Yes within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No ပ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending I 24 hours after death. 1 Natural 2 Accident injury 5 Pending 1 ☐ Yes 2 ☐ No M Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my spiritual death occurred. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 45530 Swasaelan 08-11-2010 Baltimore ND 2123

DHMH 17 Rev 7/2009

State Registrar 9114

32. Registrar's Signature

Philadelphia road,

Sulle 208

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SIUASAILAM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2010 Month 9 7:35 P.M Evelyn R. Silvia August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death GenesisElderCare-Heritage Dundalk Baltimore 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Feb27, 7. Age (In yrs. last birthday) Hours 1 □ M 2Å F Days 213-10-6581 95 1915 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6912 Gough Street 21224 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💢 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Social Security Elementary/Secondary (0-12) College (1-4or 5+) Claims Clerk 2yrs Administration 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Sordillo Mary Ryan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis Silvia 6912 Gough Street Baltimore, Md. 21224 (son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery crematory or other place) 20a. Method of Disposition August

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite. Medical Experimental the natified at Baltimore, Maryland 21215-0036

**Physician** 

/Medical

**Examiner** 

Director

Funeral

Completed by

Be

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Md.

**Funeral** 

Director

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	1 № Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	Parkwood	Cemetery 1				
-	21. Signature of Funeral Service License		2. Name and Address of Facilit $Ka$				
	Trobat I rould	$\mathcal{M}$	.201 Dundalk A	venue Bal	timore,	Md.21222	
	23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death. Do not ente	er the mode of dying, such as cardi	ac or respiratory arrest,		Approximate Interval Between	
	Immediate Cause (Final disease or condition	RESPIRATOR	RY FAILURE			Onset and Death	
	resulting in death)	Die to (or as a consequence of):	/ MILUI				
	Sequentially list conditions, b.	PAGUMONI	A				
iner	M. danu. Josephon An Jonato Marks	or as a consequence of);		2 1			
Kam	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	CORONARY 17	THEKOSCLE	ROSIS			
E E	toosaan, caot	CORONARY A Due to (or as a consequence of):  CHROHIC KID	M.C. DICK	CE			
dic	d.	CAKONIC ICID	NEY DIJER	DE			
Completed by Physician/Medical Examiner	IF FEMALE:	3c. If yes, outcome of pregnancy			00d D-+	U	
ciar	in the past 12 months?	1 Live birth 2 Fetal death 3	☐ Ectopic pregnancy ☐ Other <i>(specify)</i>		23d. Date of de Month	Day Year	
ηysi	1 □ Yes 2 ☑ No 9 □ Unknown	9 ☐ Unknown					
y P	Λ .	tributing to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did tobacco	o use contribute to	the cause of death?	
d be	MNEMIA			1 ☐ Yes	2 □ No 3 □ P	robably 4 Onknown	
plet	DEMENTI	A		24a. Was an	24b. Were au	utopsy findings available	
mo				autopsy performed?	death?	completion of cause of	
Be C	25. Was case referred to medical		26. Place of De	eath (Check only one)	NO ILITES	Z INO	
	examiner?	ospital: 1 Inpatient 2 ER/Outpatien	nt 3 DOA Other: 4 Nursing	Home 5 ☐ Residence	6 ☐ Other (Spe	ecify)	
nc:	27. Manner of Death 1 (■ Natural 5 □ Pending	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury		28d. Describe how in			
catic	2 Accident investigation		M 1 □Yes 2 □ No				
rifi	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, stree building, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rate)	ural Route Number,	
Ş							
Medical Certification: To	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my knowledge, death er: On the basis of examination and/or invand manner stated.	n occurred at the time, date and pla vestigation, in my opinion, death oc	ce, and due to the cause curred at the time, date a	e(s) and manner a and place, and due	s stated. e to the cause(s)	
Me	29b. Signature and title of certifier		29c. License number	29d. [	Date signed (Mont	h, Day, Year)	
	> Sacin Aa	In Sugar	1 177185	7 8	lulin		

ORIGINAL

arkel- Place Dundalk MD

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death August 13 Day 2010 Year Physician/ 1:45 A M Testa Victor Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Towson 8. Date of Birth
(Month, Day, Year)
Time 9, 1986 If Under 1 Year | If Under 24 Hrs. **Funeral** Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days 1 XM 2 □ F Hours 212-13-9415 Mary Land Director 24 Usual Residence of Decedent 28a-f show 10b. County 10a, State 10c. City, Town or Location 10d, Inside City Limits Director Parkville Baltimore 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21234 2920 Chenoak Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Completed by 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 🗓 No If Yes, Give 1 ☐ Yes 2 😾 No Specify: White Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Auto Service Mechanic 12 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Barbara Testa David Joseph Testa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Testa Father 2920 Chenoak Avenue, Parkville, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State August 16, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Baltimore, Maryland Bavview Crematory 2010 Signature of Funeral Service Licenses 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 23a. Part 1. Enter the disease, complications that caused the de the Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as ronsequence of): Examiner Sequentially list conditions, if any reading to immediate cause. Enter Underlying Completed by Physician/Medical Examiner Due to lor as a consequence of signed by the attending physician and Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 5 Other (sk g Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 Tyes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No 1 🗌 Yes æ 25. Was case referred to medical 26. Place of Death (Check only one) iner? Hospital 2 🗌 No 욘 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 24 hours after death.

Funeral Director. After this completed filled in by the funeral 28c. Injury at work? 1 \quad Yes Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred injury ☐ Natural 5 Pending January 12, 2007 cn Ynows 2 X No Accident Investigation 6 Could not be Suicide 28e. Plac f Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the F only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) 0

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25477 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 5.2010 Dorothy Huggins Trimble 3:42 Рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min December 291947 215-50-1056 Marvland 62 Yrs Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits must be notified at Director Baltimore 1 Yes 2XXNo Marv1and Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 5440 Whitlock Road 21229 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 'natural", or \$ 1 Never Married 2 Married Yes 2 TNo 1 ☐ Yes 2 🖟 No Specify: White If Yes, Give Year or Dates. Specify 3 Widowed 4X Divorced Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) 12 College (1-4 or 5+) Martins Seafood Accountant Be 17. Father's Name (First, Middle, Last)
George Darby 18. Mother's Name (First, Middle, Maiden Surname) ပ Jean Cook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Trimble/ Son 760 E. Fort Ave., Baltimore, Maryland, 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory August6,2010 Glen Burnie, Maryland 22. Name and Address of Facility Gary L. Kaufman Funeral Home. Inc 21. Signature of Funeral Service Licenses 7250 Washington Blvd., Elkridge, Maryland, 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Metasta disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) physician and the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Unknown Hospital or Attending Physician: The law requires that the signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page death? 1 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 5 Pending work? after death. 2 No ☐ Accident ☐ Suicide Investigation the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 To the 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mon MANUES MO 6700

Registrar
DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year,

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

32. Registraris Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical **Examiner** City, Town, or Location of Death 4c. County of Death N/A . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F (Month, Day, Year) 11/8/1939 Months Hours Min. 213-38-5999 **Director** MARYLAND 70 Usual Residence of Decedent rral", or items 23a or 28a-f show Examiner must be notified at 10a. State filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director MD N/A 1 X Yes 2 No BALTIMORE CITY 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 4100 N. CHARLES STREET APT. 1015 21218 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 XMarried Maryland 21215-0036 1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates Specify "natural", Specify: Completed 3 Divorced BLACK Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other the any injury or other traumatic event, the I OFFICE MANAGER 12TH GRADE MEDICAL Be Jir.

Ji. Page 1 and 2 should us...
artment of Health and Mental H.

When 27 is marked of 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ GARFIELD BROWN MARIE MARSHALL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21218 RICHARD D. TRAVERSARI/HUSBAND 4100 N. CHARLES STREET 1015 BALTIMORE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) METRO CREMATORY, INC. 8/11/2010 | CATONSVILLE, MD . Signature of Funeral Service Licensee MOO212 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, 8521 LOCH RAVEN BLVD. TOWSON, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician, disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Live Birth 2 Live Birth Pregnant at time of death in the past 12 months?
1 Yes 2 No 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 1 Yes 2 No Yes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Tes 2 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA After this ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death Certificate; Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury work? Natural ... 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined within 24 hours a

To the Funeral D Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. pature and 29c. License number

State Registrar who completed cause of death (Item 23a) (Type, Print)

weller with

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 10 Day Physician/ 12:40PM 2010 Medical or Location of Death 4c. County of Death 4a. Facility Name (if not institution, **Examiner** 15, timore tvenue nor If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign last birthday **Funeral** Months Min. Country) 1 M 2 KF Director Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. In the marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location Funeral Director 1 Yes 2 ☐ No HMOPE 10g. Citizen of What Country? 10e. Street and Number 57nor Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces?
1 ☐ Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 25 No Baltimore, Maryland 21215-0036 Specify If Yes, Give Year or Dates. 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry nday (0-12) College (1-4 or 5+) Be . Father's Name (First, Middle, Last) ပ 19b. Mailing Addı Place of Disposition (Na 20a Method of Disposition ematory Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart foliure. List only one cause on each line. Approximate Interval Between Onset and Death CEREBROVASCULAR ACCIDEN Immediate Cause (Final disease or condition ACUTE Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence on After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the bunal-transit Cause (Disease or iinjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No
9 Unknown Pregnant at time of death 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 TYes 2 은 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after deal To the Funeral Directors filled n by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one 29b. Signature and little of certifie 29d. Date signed Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AGNES COLE

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

ar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 12 2010 2010 Frances Elizabeth Varnum 11:14 A<sup>M</sup> Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2703 Glendale Road Parkville Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Days 1 . M 2 X F Months Min Jan. 17, 1912 214-50-0900 Marviand Director 98 Usual Residence of Decedent Show 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD 1 Yes 2 No Parkville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 2703 Glendale Road 21234 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🔀 No If Yes, Give Year or Dates 1 Yes 2X No Specify: white Specify: Completed 3 Widowed 4 Divorced Maryland 21215-0 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Greater Baltimore other than Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health and Mental Hygiene, ant: If item 27 is marked other tha Medical Center Registered Nurse 12 Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George W. Lushbaugh Viola M. Mowen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21136 6419 Wilmont Drive- Reisterstown, Maryland 19a. Informant's Name/Relationship (Type, Print) Susan V. Ehman-daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Dulaney Valley Memorial Gardens Department of 1 🗶 Burial 2 □ Cremation 3 □ Removal from State Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Aug. 16, 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 andraé Korri Farold 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ cevebrovascular accillent disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to for as a consequence of within 24 hours after death.

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1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☑ No Pregnant at time of death Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 ☐ Yes 2 M No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s Detifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) 2010 D0056156 30. Name and appress of person who completed cause of death (Item 23a) (Type, Print) Caccamed 6565 Norm ( Lordes Street Baltonion, Maryland Zizoy Suzanne M w 31. Date filed (Month, Day, Year 32. Registrar Signatur State AUG 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 26 per doc g906 8-16-10 vt. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2010 Certificate of Death 1. Decedent's Name (First, Middle Last) 2. Date of Death August 4, 2010 **Physician** 5:30 P. M Mabel Louise Ward /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel County Tate House Linthicum 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Day, Sep. 26, **Funeral** 6. Sex Age (In yrs. last birthday) Months Days Hours Min 1 ☐ M 2 1 F 93 1916 Virginia 230-24-0380 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location show th and Mental Hygiene. 77 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Exagramments to motified at 1 ☐Yes 2 ☑ No Director Maryland Anne Arundel Co. Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? within 72 hours after death with U.S.A. 21076 6 Leeds Road by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental HI Important: If Item 27 is marked othany injury or other traumatic event Be William Henry Polk E. Strawderman Mary 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James R. Ward, Sr. (son) 6 Leeds Rd. Hanover, Maryland 21076 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Park Aug.9 Elkridge, Maryland 22. Name and Address of FacilityGary L. Kaufman Funeral Home @ 21. Signature of Funeral Service Meadowrdige Mem.Park,Inc.7250 Wash. Blvd.21075 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest stock, or heart failure. List only one cause on each line. Approximate Interval Between (1) N Onset and Death nmediate Cause (Final **Physician** yrs. disease or condition resulting in death) A.S.C.V.D. /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed burial-tran and Due to (or as a consequence of) Box 68760, physician Physician/Medical the attending pl IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕅 No Month Day Year 5 Other (specify) P.O. the 9 Unknown bee signed by the should be detech-Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð Complications of Left Hip Fracture 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Dementia The law certificate has be rector, page 2 s 24a. Was an autopsy performed? Yes 2X No 1 □Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 3 Nursing Home 6 Nother (Specify) hospice 1X Yes 2 □ No After this funeral dire 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Injury 1 Natural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐Yes 2 No 05/31/10 0330 2 X Accident Subject fell at home 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Residence 6 Leeds Rd. Hanover, MD.21076 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) D-63726 08,06,2010 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kunmi Majekodunmi, M.D. 1406 S. Crain Hwy. Glen Burnie, Maryland 21061

State Registrar 31. Date filed (Month, Day Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Earl Lafayette Wilder August 2010<sup>ear</sup> 2:55 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death Dove House Carroll Westminster 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🕱 M 2 🗆 F Months Days Hours September 29,1921 220-14-4793 Kentucky Director 88 Usual Residence of Decedent 28a-f show 10a. State 10b County iral", or items 23a or 28a-f sho Examiner must be notified at within 72 hours after death with the Maryland 10c, City, Town or Location Director 10d. Inside City Limits Maryland Frederick Frederick 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2646 Cameron Way 21701 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black White etc 1 ★ Yes 2 No If Yes, Give Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify: White "natural" Completed 3 XXWidowed 4 ☐ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 r. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Moditions." 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Shop Foreman Baltimore Transit Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Roy E. Wilder Freda Ballsinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances M. Crist (Daughter) 2646 Cameron Way Frederick, Maryland 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ☐ Burial 2 🛣 Cremation 3 🗀 Removal from State Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 8-14-2010 Glen Burnie, Maryland 21. Signature Funeral Service Licenses 22 Name and Address of Facility Witzke Funeral Homes, 5555 Twin Knolls Road Inc. Columbia, Maryland 21045 23a. Part 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one c Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Examiner INFECTION CINARI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) by the attending physician and tached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Dav Year sate has been signed by the a page 2 should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò DEMENTI A Completed 1 Yes 2 No 3 Probably 4 Unknown ACUTE RENAL FAILUR 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 certificate 1 Yes within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

൧

32. Registrar's Signatur

Crossroads or sti 340

29d. Date signed (Month, Day, Year)

lungs mills, md 2111

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 13 Day 2010 Year 1:30 A M Bernadette A. Warfield Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Sykesville Carroll Brinton Woods Social Security Number Age (In vrs. last birthday, If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 1 F Days Hours Min 8 17 19 2 I Director 215-18-3737 89 MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🄀 No MD Baltimore Woodstock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States Funeral 10720 Davis Ave 21163 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Force Black, White, etc. þ 1 Never Married 2XXMarried 1 ☐ Yes 2 K No Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed)  $\begin{array}{c} \text{Elementary/Seconday (0-12)} \\ 12\text{th} \end{array}$ College (1-4 or 5+) Homemaker her home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Everisto Graziani Catherine Zavirusha 19a. Informant's Name/Relationship (Type, Print)
Franklin E. Warfield (husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $10720~{\tt Davis}~{\tt Ave}~{\tt Woodstock},~{\tt MD}~21163$ Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Crematory : 8/13/2010 Winfield, MD 21. Signature of Fund 22. Name and Address of Facility Burrier-Oueen Funeral Home and Crematory, 1212 W. Old Liberty Rd. Winfield, MD 21784 esa. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Inset and Death Physician/ Medical resulting in death) Due to (or as a consequence of): **Examiner** Seque tially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown signed by the atte 4 Pregnant : 9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an within 24 hours after death.

To the Funeral Director: After this certificate has performed 2 - N 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 🗌 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident work?
1 Yes 2 No Investigation completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

29b. Signature and

Date filed (Month, Day,

**AUG 16** 

certifier

and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

State Registrar 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item | per doc g906 8-16-10 vt
State of Maryland / Department of Health and Mental Hygiene 25484 State Registrar Certificate of Death No 1. Decedent's Name (First, Middle, Last) Samje Wright 2. Date of Death 3. Time of Death Physician/ U5 U84 1:38 AM Olo Medical **Examiner** 4a. Facility Name (if not institution, give str 4b. City, Town, or Location of Death 4c. County of Death IMUI NA If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign (Month, Day, Year 1**火** M 2 □ F 79 251-40-7931 Country) Director Yrs Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD NA XX Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1647 Ν. Mi<u>lton</u> Avenue USA 21213 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. African þ 1 Never Married 2XXMarried 1 X Yes 2 □ No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: American Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) University of Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeping 8th Grade Maryland NΑ Be 17. Father's Name (First, Middle, Last) Should be file and Mental H 18. Mother's Name (First, Middle, Maiden Surname) Session Issom Wright Martha Wright permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) MD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edith Wright-Wife Avenue Apt.#329 Baltimore Central Ν. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 08-18-10 Owings Mills, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore,MD 21217 23a. Part 1. Enter the disease, or complicitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year ☐ Pregnant ☐ Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 N certificate 1 ☐ Yes 2 🔏 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ျ 1 Tes Other: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 [ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 31. Date filed (Month, Day, Year State Registrar

DHMH 17 Rev 7/2009

Box 68760

P.O.

Records,

**Division of Vital** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 25485 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Thomasenia Ware 20<sup>Year</sup>0 1:10P M Aug Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2861 W. Lanvale Street Baltimore NA . Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign Country) SC **Funeral** 1 🗆 M 2 🗀 XF 214-50-1177 92 Days Hours Min. 1(Month Day, Year) Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 sho 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD NA Baltimore 1 ¥ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2863 W. Lanvale Street 21216 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2X No Black, White, etcAfrican þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes Give 1 Yes XXNo Specify: Specify:American Completed 3 Nidowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working life. DO NOT use retired)

Social Worker Assistant Elementary/Seconday (0-12) 12th Grade College (1-4 or 5+) Children Society Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Jacob Littles Addie Littles Coleman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Slyvia Banks-Fisher 2861 W. Lanvale Street Baltimore, MD 21216 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Zion Cem. 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08-13-10 Lansdowne, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Wylle Funeral Home P.A. 638 N. Gilmor Street Baltimore, MD 21217 232 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interv Letween One Land Data Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year the signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2: autopsy performed? 2 No ☐ Yes 2 📈 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tes Other: ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of I Director: After to ad in by the funeral 28c. Injury at 28d. Describe how injury occurred 1 ANatural 5  $\square$  Pending work 1 Yes ☐ Accident ☐ Suicide 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours of To the Funeral I Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Number Practioner: To the desired my knowledge at the country of the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

BALTIMONE, MD

THERRE

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2 un 0 45 M Shiksha Wati Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Levindale Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) India 8. Date of Birth **Funeral** 1 □ M 2 😾 F Months Days Hours Min. 3 (Month 1 Day Year) **Director** 216-98-8492 86 Usual Residence of Decedent show 10a. State 10b. County items 23a or 28a-f sho ner must be notified at 10c. City. Town or Location filed within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 Yes 2 K No MD Gaithersburg Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20878 USA 925 Pointer Ridge Drive 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) n "natural", or iten ledical Examiner r 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 X Widowed 4 ☐ Divorced SpecifyAsian Indian Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Home Maker Be other traumatic event, Department of Health and Mental H Important: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Chima Wati Chiranji Lal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Subodh Agrawal 925 Pointer Ridge Drive Gaithersburg, MD 20878 Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 8-16-2010 Arundel Crematory | Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) <sup>22</sup> Name and Address of Funeral Home & Crematory, 1411 Annapolis Road Odenton, Maryland 21113 M01176 Part 1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final et/and Death Physician/ disease or condition Medical resulting in death) Due to (or as a con **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a co the Hospital or Attending Physician: The law requires that the death certificate be executed be detached for use as the burial-transit been signed by the attending physician and Due to (or as a consresulting in death) Last u nce of Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 \_\_ Live Birth 2 \_\_ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box ( 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Dav Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 110 မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Man f Death Certificate: Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? Natural 5 Pending injury Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier X 2010 30. Name and address of prison who completed cause of death (Item 23a) (Type, Print) 34 2 A m State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** August 10:17 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Hospital of Beltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1€M 2□F Days Hours 214-62-5168 Usual Residence of Decedent 5 Director death with the Maryland 10a. State 10b. County 10c. City, Town or Location 0d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Modical Examinations be notified at 1 Yes 2 No Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗗 No ģ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within and Mental Hygiene. College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ 19a. Informant's Name/Relationship 19b. Mailing Address (Street and Number or Regral Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 🕏 Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) uneral Service Licens 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Ventricular Fibrillation disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy After this certificate has been signed by the atte funeral director, page 2 should be detached for u in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Hypertension 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? Director: After this certificate has 2 No 1 🗌 Yes 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 □ No Certification: To 1 Yes 1 ☐ Inpatient 2 🗷 ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 | Pending 1 ☐Yes 2 ☐No investigation within 24 hours after death.

To the Funeral Director: / 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D59062 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bultimore Chad J. Hanson M. State

DHMH 17 Rev 1/2001

Registrar

Williams

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Jour Reflee VV	aikei	1-For State Registrar Reg. No.	
Physic Medical Exan		1. Decedent's Name (First, Middle Last)  2. Date of Death  Month  Day  Year	3. Time of Death
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death	
trage of the		6340 Frederick Road Catonsville Baltimore Coun  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birth	
Funera Directo		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 F   Usual Residence of Decedent 7. Age (In yrs. last birthday) 1 M 2 F   Hours Min.   Min.	
nd show any cc.		10a. State 10b. County 10c. City, Town or Location	1 Yes 2 No
r death with the Maryland or items 23a or 28a-f show must be notified at once.	Director	10e, Street and Number (6340 Frederick Road 21228 10g. Citizen of What Country USA)	у?
r death with or items 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - America White, etc.	an Indian, Black,
urs after tural",	l by	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done)  16b. Kind of Business/Ind	dustry
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene, and the fire 27 is marked other than "natural", or items 23a or 28a-f sho or other tranmatic event, the Medical Exeminer must be notified at once.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired) Howard	County Hospital
21215-0036 Juld be filed within 7 Mental Hygiene. Marked other than ic event, the Media	ပိ	17. Father's Name (First, Middle, Last)  Anthony  Payton  18. Mother's Name (First, Middle, Maiden Surname)  Harriet Taylo	0
212 ould be I Menta market	To Be	19a. Informant's Name/Relations p (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z	
Baltimore, MD 21215-00; permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene Important. If item 27 is marked other unjuny or other traumatic event, the Mental Hygiene.		Harrier A. Payton-mother 1919 Hillcrest Rd. Gwynoak, ms.	/
Baltimore, MC Demit. Pages 1 and 2 s. Department of Health at important: If item 27 niury or other traums.		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or To	own, State
Baltime Department Department Important:		4 Donation 5 Other Specify: A Chattus mem. P.C., 8-10-2010 Arbutus 27 Ignature of Funeral Service Lice 22. Name and Address of Facility 3405 W. Franklin	, MD.
Balti permit. Departm Imports		Mildel M. Cerelas of Nancy m. Wallace F.S. Basto, md	1. 21229
Physiciar /Medica		23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and
Examine		Immediate Cave (Final disease or condition resulting in death)  Diabetic Ketoacidosis  Due to (or as a consequence of):	Death
	L	Sequentially list conditions, b	
	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or hiju, y that initiated c	
ecuted and - transit	al Exal	events resulting in death) Last Due to (or as a consequence of):	
60, ate be ex hysician e burial	Medical	▼ UNPENDED AMENDED 23a,pt.II,27 per me g906 8-25-10 vt	
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/M	IF FEMALE: 23c. If yes, outcome of pregnancy 1	y Year
D. BC the de: by the a	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the	e cause of death?
, P.C. res that signed be deta	d by	Atherosclerotic Cardiovascular Disease 1 Yes 2 No 3 Probab	oly 4 🗸 Unknown
ords w requi s been should	Completed		osy findings available appletion of cause of
Reco	E	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes	2 No
ital ician: s certif	BB (	25. Was case referred to medical examiner?  1	e-p
of V ig Phys fter thi	일	1 Ves 2 No language 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: S  27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred	cene
sion ttendir death. ttor: A	atio	1 X Natural 5 Pending 2 Accident Investigation 1 Yes 2 No	
Division of Vital Records, P.O. bpital or Attending Physician: The law requires that the outs after death. After this certificate has been signed by filled in by the funeral director, page 2 should be deach	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural or Town, State)	Route Number, City
To the Hor within 24 h To the Fur completely	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cand manner stated.	ause(s)
	Σ	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month).  August 5, 2010	, Day, Year)
6)		30. Name and address of person who completed cause of death (Item 23a)  Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
9	tate	31. Date filed (Month, Day, Year) 32. Redistrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2010 August 10 Physician/ Yuen-Pai Young Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Montgomery Burtonsville Holy Cross Nursing & Rehab Birthplace (State or Foreign Country)
 China If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday, Social Security Number 6. Sex Days Funeral Months 1 □ M 2 🔽 F 77 049-66-1074 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show 10b. County 10a. State permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shoi any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Columbia Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number China 21046 Funeral 9629 Morning Leap Terrace Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc. Armed Forces?

1 Yes 2 X No 1 Never Married 2 K Married þ 1 ☐ Yes 2 X No Specify: Specify: Asian 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Hsi-Ying Pan Fang-Han Chen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9629 Morning Leap Terrace Columbia, MD 21046 Ronald J. Young/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 10/11/2010 Atlantic Crematory 22. Name and Address of Facility
Witzke Funeral Homes,
5555 Twin Knolls Rd., 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or conditi resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Physician/Medical Examinel been signed by the attending physician and should be detached for use as the burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 C Ectopic pregnancy 5 Other (specify) Month Day in the past 12 months?

1 Yes 2 No Pregnant at time of death 9 Unknown 1 ☐ Yes 2 ☐ 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 s has 2 1 🗌 Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 within 24 hours after deau.

To the Funeral Director: After this and annual section of the funeral directions and the funeral directions. 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Manner of Death Certificate: injury Natural 5 Pending 1 Yes 2 No Accident Investigation 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide determined City or Town, State) 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

mpleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 25490 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9:30AM Medical City, Town, or Location of Death Examiner 4c. County of Death TMORE last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2**X**F Months Hours Min. Director 10c. City, Town or Location Completed by Funeral Director 10d. Inside City Limits 1 Yes 2 🗆 No timore 10g. Citizen of What Country? 10f. Zip Code Was Deceus. Armed Forces? ☐ Ves 2 No 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Kind of Business Industry (Give kind of work done during most of working Janei life. DO NOT use retired) conday (0-12) College (1-4 or 5+) Be 's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnar မ Informant's Name/Relationship (Type, Pri 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4000 Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) 21. Signature of Funeral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ₹nysiciaπ sterine disease or condition resulting in death) cancei Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to in a Claticause. Enter Underlying Cause (Disease or iinjury Examiner Due to (unes a not enqueries of): To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and thed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year 1 ☐ Yes ∠ L 9 ☐ Unknown Unknown this certificate has been signed by tral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by I 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 🗆 Yes 2 **X**No ၉ Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: /
completed filled in by the 1 Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MO 00070635 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 6701

Svite 4105

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Albert F. Augustyniak Sr. 2010 Medical August 11:15å 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Riverview Nursing Center 8. Date of Birth (Month, Day, Year) v 25, 1919 Baltimore Essex Social Security Number Age (In yrs. last birthday, If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min. 1 \rbrack 🕍 2 🗆 F Months 218-03-2288 Hours Director 91 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MD Baltimore Essex 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code s 23a o 10g. Citizen of What Country? by Funeral 16 Wagners Lane 21221 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian "natural", or ite Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3 XWidowed 4 Divorced Year or Dates. the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than "r imatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Line Worker GM8th it. Page 1 and 2 should be filed wi rtment of Health and Mental Hygir rtant; If item 27 is marked other njury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frank Augustyniak Mary Kalacyuska 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Albert Augustyniak Jr./son 16 Wagners Lane Balto. MDBaltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important; If ite any injury or other Date □ Burial 2 □ Cremation 3 □ Removal from State Holly Hill Cemetery 8/14/10 Baltimore MD 4 ☐ Dopation 5 ☐ Other (Specify) 21. Sign turn of Funeral Sewice License 22. Name and Address of Facility 300 Mace Ave. Balto. Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician eumonic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter concerning Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): resulting in death) Last signed by the attending physician d be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Unknown 1 ☐ res ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy within 24 hours after death.

To the Funeral Director, After this certificate I completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: ၉ 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify, Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 45 AM 5 Pending work?
1 Yes 2 No ☐ Natural Fell from the bed 3/2010 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined NUrsing hone Eastern Blud within 24 hours a Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 30. Name and address of person wh o completed cause of death (Item 23a) (Type, Print) Ph 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25492 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 ear Albrecht, 1:53  $\mathbf{P}^{\mathsf{M}}$ Arno1d John Sr. August Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Towson Baltimore Gilchrist Center 1 Year If Under 24 Hrs Social Security Number 7. Age (In vrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🕱 M 2 🗆 F Months Hours (Month, Day, Year Director 215-34-5646 73 Jan Mary land Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. I ant If item 27 is marked other than "natural", or items 23a or 28a-f shor lury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland | Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 10313 Greentop Road 21030 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Plastic Container College (1-4 or 5+) Elementary/Seconday (0-12) 12 Mechanical Electrician Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည **Albrecht** Marie Teresa Gutsmiedl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arnold John Albrecht, Jr./Son 10313 Greentop Road, Cockeysville, MD 21030 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of IImportant: If ite
any injury or ott
once. 20c. Location - City or Town, State 8/18/10 🕱 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Donation 5 Other (Specify) Dulaney Valley Memorial Gardens Timonium, Maryland 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. vary O W. Padonia Road, Timonium, MD 23a. Part 1 Enter the disease shock, or heart failure. L r the disease or complications eart failure. List only one cause hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying attending physician and I for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 2 No the g 🗌 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown peen . Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? After this certificate 2 🗌 No 1 Yes Yes eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical l e 26. Place of Death (Check only one) examiner? Hospital 2 🕅 |은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Matural injury 5 Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one Signature License number 29d, Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's signatur

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #2,310f&19a&b Per ANA BD G906 8/12/2010 JH G906 8/12/2010 JH G906 8/12/2010 JH G906 BD G906 8/31/2010 JH G906 BD G90 State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of DeathAug. 07, 2010 Physician/ BROWN LEO Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BON BAZTIMORE SECOURS HOPPITAL Social Security Numbe If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign Funeral 1 ☒ M 2 ☐ F Hours Min 0ct 18, Year) 932 Director 77 Mary Tand 212-30-4000 Usual Residence of Decedent or 28a-f show be notified at 10a. State 10b County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Baltimore 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code items 23a or ner must be n 10g. Citizen of What Country? Funeral 21217 21223 1510 W. Lanvale Street USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Examiner Black, White, etc. ь Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 black 1 ☐ Yes 2 No Specify: "natural", Specify: 3 Widowed 4 Divorced Year or Dates Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. ant; If item 27 is marked other than "natur ury or other traumatic event, the Medical. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry Unit (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Ò handyman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Wilson Brown Leola Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Medley 3533 Elmley Avenue; Baltimore, Maryland 21213
1510 W. Lanvale Street, Baltimore, MD 21217
Disposition (Name of Date 20c. Location - City or Town, State brother Stephanie Miles/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State 4 ☐ Donation State permit. Page Department of Important: If any injury or 8/21/2010 Baltimore, MD Metro Crematory 21. Sign time 4 envice Licensee tonal d S Water 22. Name of Address of Facility State Angtony Board Howe I Home  $\frac{MD}{MD} = \frac{21201}{21207}$ 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line. 4600 Liberty Heights Ave Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician. PERSISTANT SEPTIC SHOCK Medical Due to (or as a consequence of): Examiner MONTHS GAZLBLADDER NECRUTIC Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a consequence on 15 STAGE Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit CARDIOMMOPATH resulting in death) Last Due to (or as a consequence of): Physician/Medical DISEASE EARS ANTHEROSCLEROTIC CARDIOVASCULAR Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 menths? Month 1 Yes 2 M 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MERLITUS DIABETES 1 Yes 2 No 3 Probably 4 Unknown DISEASE DUE TO NON AZCOMULIC LIVER Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy STEATUSIS SEVERE MAZ NUTRITIEN perform After this certificate Yes 2 1 ☐ Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မြ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? Natural iniury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
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Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D66335 herhiteld AUGUST 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREENE ST SHEW FAD 22 SOUTH MD 32. Registrar's S State Registrar

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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the b.	Medical	(Check 2	Medical E	xaminer: 0	on the basis of	f examination	and/or invest		ion, death occurr	ed at	the time, date a	and plac	ce, and due	to the cau	se(s) and manner stated.
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10-06009 Nancy Marie Bianca Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 25495
State of Maryland / Department of Health and Mental Hygiene

Position from the content of the c			1- For State Certificate o	f Death	Re	g. No.	
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Physician  Machine  Examinor    Application   Connecting   Funeral Home   Fissex   21221	Salti ermit. epartri nport			. 3	00 Mac	e Ave. Ba	lto. MD
Tally No Organization   Tally		9 8	230 Part Lester the disease or complications that governed the feeth De and extent	Connelly Fun	eral H	ome of Es	
Segmentally list conditions, if any leading to immediate clause (Final disease or condition resulting in death). Last the list of the list			failure. List only one cause on each line.	tie mode of dying, such as caldiac o	respiratory arre	st, snock, or neart	Between Onset and
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25. Was case referred to medical examiner?  1	\ 0 7 7 7	edic					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    23e. Did tobacco use contribute to the cause of death?		-	23b. Was decedent pregnant in the	tal death 3 Ectopic pregna	ncv		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    23e. Did tobacco use contribute to the cause of death?	th cert	icia	past 12 months?				,
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29b. Briggature and title of certifier  29c. License number  O.C.M.E.  29d. Date signed (Month, Day, Year)  August 11, 2010  30. Name and address of person who completed cause of death (Item 23a)  Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	Di pital ours a ceral I	Sert	4 Homicide determined (Specify)		or rown, Sta	ate)	
29b. Briggature and title of certifier  29c. License number  O.C.M.E.  29d. Date signed (Month, Day, Year)  August 11, 2010  30. Name and address of person who completed cause of death (Item 23a)  Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	ne Hos n 24 h ne Fun sletely		(Check only Certifying Physician: To the best of my knowledge, death occur			• •	
30. Name and address of person who completed cause of death (Item 23a)  Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	To th withi To th comp	<b>l</b> edi	and manner stated.				
30. Name and address of person who completed cause of death (Item 23a)  Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201		-				-	ui, Day, real)
Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			Court C				
State 31. Date filed (Moeth, Day Year) 32. Registrar's Signatur	[			enn Street, Baltimore, MD	21201		
			31. Data filed Worth Day Year 32. Registrar's Signatur				

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			For State Registrar	State of Ma	aryland /	Depa Cen	rtment of F tificate of D	lealth and Death	d Mental H	ygiene Reg. No	201	0	25496	
	Physicia		Decedent's Name (First, Middle, L MARTIN BOEGNER,	,					2. Date of I		ž, 20°i̇̃	ð	3. Time of Death 3:20 P <sub>M</sub>	
	Medic Examin		4a. Facility Name (if not institution, gi	ve street and number)			4b. City, Town, or BALTIM		ath		c. County of Death			
	Funeral Director		5. Social Security Number 6. 219-56-6971	4 🗆 4 4 6 🗆 =	(In yrs. last t	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi			49	Birthpla Country	ace (State or Foreign y) MD	
	nd now at	ī	Usual Residence of Decedent  10a, State  10b, County		10c, City, To	own or Loc	ation					110	0d. Inside City Limits	
	Aarylar 8a-fsl tified	recto	MD N/A		•	TIMO					1 X Yes 2 □ No			
	with the I s 23a or 2 lust be no	Funeral Director	10e. Street and Number 3710 OVERLEA AVE				10f. Zip Code 21206			10g. Ci US.	tizen of What A	Countr	ry?	
980	be filed within 72 hours after death with the Maryland ental Hygiene. Ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	by	11. Marital Status  1 ☐ Never Married 2 【 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Every Armed Forces?  1		l If	/as Decedent of Hi Yes, specify Cubar ☐ Yes 2 No	n, Mexican, Pue	(Specify Yes or N erto Rican, etc.)	0-	14. Race - A Black, W Specify:		tc.	
Maryland 21215-0036	12 should be filed within 72 hours a stath and Mental Hygiene. 27 is marked other than "natural r traumatic event, the Medical Ex	Completed	15. Decedent's (Specify only highest Elementary/Seconday (0-12) 12			(Give k life. DC	ent's Usual Occupa ind of work done d ONOT use retired) RIAL HAN	uring most of w	vorking		(ind of Busine	ess Indu	ıstry	
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, Mary	of Health and Ment of Health and Ment fitem 27 is marked rother traumatic e		19a. Informant's Name/Relationship SHERRI BOEGNER-V		1	9b, Majlind 3710	o Address (Street a	nd Number or I AVE B	ALTIMORI	ber, City o	<sup>T</sup> 21,206	Zip Co	nde)	
Baltimore,	Page 1 an ment of He tant: If iten ury or oth		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		ceme	etery, crem	sition (Name of atory or other place CEMETER		Date /16/10		ocation - City $ALTIMO$			
Balt	permit. Page Department of Important: If any injury or once.	99	21. Signature of Funeral Service Lice	nsee		10 100	Name and Addres		ILLER-DEBALTIMO				HOME, INC	
P	h, sician/	F 10	23a. Part 1. Enter the disease or co shock, or heart failure/ List only Immediate Cause (Final disease or condition	mplications that caused one cause on each line.	7/4-2		r the mode of dying					1	Approximate Interval Between Onset and Death	
	Medical Examiner		resulting in death)	Due to (or as a	c ned jueno	e of):								
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9	ate be executed physician and the burial-transit	edical Ex	resulting in death) Last	Due to (or as a	consequenc	e of):								
Box 687	to the hospital or Attending Priysician: The law requires that the death certifical within 24 hours after death.  To the Funeral Directors After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	Fetal de		Ectopic pregnanc	У		-	23d. Date of Month		y Day Year	
IS, P.O.	uires that the signed by ald be detact	by	Part II. Other significant conditions	contributing to death bu	t not resultin	g in the ur	nderlying cause giv	en in Part I.					e cause of death?	
Vital Records,	: I ne law req cate has bee page 2 shor	Completed							_ pe	as an topsy rformed? s 2	prior	to com	sy findings available apletion of cause of	
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on of	nding Pny ath. : After this e funeral d		27. Manner of Death  1 Natural 5 Pending 2 Accident Investigat	28a. Date of injury (Month, Day,	/ 28b	o. Time of injury	28c. Injury work		28d. Describ			oecity)		
DIVISION OF	al or Atters s after dezal Director	Certificate:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine	be 280 Place of Injur		farm, stre	et, factory, office					Rural Fi	Poute Number,	
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	with Con		29b. Signature and title of certifier	<b>~</b>			29c. License	number 4/27/			te signed (Mo		ay, Year)	
			30. Name and address of person who	A -T			rint)	2100	13	L3				
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raig Labron Bo		State of Maryland / Department of For State  Certificate of L			
Physici	20/	Registrar  **Decedent's Name (First, Middle, Last)	70007	Reg. No. 2. Date of Death	3. Time of Death
Priysici Redical Exami		Craig Labron Boule		Month Day August 5, 2010	Year 0306 hrs
			City, Town, or Location of Death Randallstown		County of Death altimore County
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)  26	If Under 1 Year If Under 24Hrs Months Days Hours Min.	<b>⊣</b>	DDYYYY) 9. Birthplace (State or Foreign FloRIDA) Country)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grace completed) Elementary/Secondary (0-12) College (1-4 or 5+)  17. Father's Name (First, Middle, Last)	10f. Zip Code  2 1244  Decedent of Hispanic Origin? (Sp., specify Cuban, Mexican, Puerto  es 2 No specify:  Usual Occupation (Give kind of v. t of working life, DO NOT use reti	work done ired)  We (First, Middle, Maiden S	
Baltimore, N permit. Pages I and 2 Department of Health Important: If item 2 injury or other traus		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Sign of Puneral Service Specify: 22. Nan	ematory 8-2.	1-2010 20c. La 16-10 Con 16-10 Con	tonsuive mD
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Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transi	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal	death 3 Ectopic pregna		. Date of delivery Month Day Year
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Vital Rec hysician: The this certificate	o Be	examiner? 1 \( \subseteq \text{Yes}  2 \) No  Hospital: 1   Inpatient 2 \( \subseteq \text{ER/Outpatient}  3 \)	- Voltan -	ng Home 5 Residen	nce 6 Other:
ion of \text{tending Phy} eath. tor: After the funeral of	-	27. Manner of Death 1 Natural 5 Pending Pound: Day, Year) 28a. Date of Injury FOUND: 28b. Time of Injury FOUND: FOUND:		28d. Describe how injur Subject shot	y occurred
Divisic pital or Atte ours after des eral Directo	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined Suicide 1 Aug 5, 2010 0213 hrs 28e. Place of Injury - At home, farm, street, (Specify) At home	factory, office building, etc.	or Town, State)	nd Number or Rural Route Number, City
Division  To the Hospital or Attency within 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier (Check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred one)  2 Medical Examiner: On the basis of examination and/or investigation		due to the cause(s) and	manner as stated.
To To To Com	Med	29b. Signature and title of certifier	29c. License number	29d. D	Date signed (Month, Day, Year)
		m m, no	O.C.M.E.	Augu	ust 5, 2010
		30. Name and address of person who completed cause of death (Item 23a)  Ling Li, MD Assistant Medical Examiner 111 Penn Street,	Baltimore, MD 21201		
S Regis	tate trar	31. Dalefil G (Aprilla Barrice) 32. Registrate Signature			

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State Registrar

MARCIA

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25499 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Kenneth Wilson Bond 2010 7:45pm August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 699 Gist Road Carrol1 WEstminster 6. Sex 1 **X** M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 4-4-195 Tear) 59 Director 220-84-8413 MD Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director Examiner must be notified 1 ☐ Yes 2 🏋 No MD Carrol1 Westminster 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò Funeral 23a 699 Gist Road 21157 United States and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 ANo Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married ò þ 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White "natural", 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Not Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental J. Kenneth Bond Jean Egolf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean McAvoy (Mother) 68 Timber Ridge Dr. Westminster, Md 21157 or other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Page 1 a
Department of F
Important: If ite
any injury or ot 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Evergreen Mem. Gardens 8-19-2010 Finksburg, MD Jure of Fune of Service Censes 22. Name and Address of Facility Eline Funeral Home 11824 Reisterstown Rd. Reisterstown, 21136 J. Wayne Osterling MDse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23 . Part 1. Ente the disea Approximate Interval Between shock, or heart failure. List only one cause on each line set and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine Due to to if any, leading to immediate physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 1 ☐ Yes 2 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 1 1 🗌 Yes 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ည 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Matural Natural 5 Pending 1 Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu Investigation Accident 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 3 ☐ Suiciae 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

xaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying 29a. Certifier (Check Medical Certifying Nurse Practigner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certific 30. Name and address of perso (Item 23a) (Type, Print) Drive Suite 34 Westminster Day, Year) 31, Date filed (Month, Day, Ye. 32. Registrar's Siglature State Care Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) Kailee Mae Fenix Bain-Janowiak 2. Date of Death Day 200PM **Physician** 08 2010 BAIN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALRMORE UNWESSIT OF MANYOUD MEDIAL CTR If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1 0 7 / 3 0 / 201 0 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Sex 1□M 20 F MD Ountry) Min Months Hours N/A Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show the Medical Exercitour must be notified at MD Baltimore Baltimore 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21229 4422 Alan Dr. Apt. E. 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Items 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: hours after <sub>Specify:</sub> White 1 Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 □Yes 2 No ō Specify: \$ 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 72 (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. d 2 should be filed within 7 th and Mental Hygiene.
7 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Christine Mae Bain John Christopher Janowiak 19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4422 Alan Dr. Apt. E Balto, MD 21229 19a. Informant's Name/Relationship (Type. Print)
Christine Bain/Mother permit. Pages 1 and 2:3 Department of Health a Important: If item 27 is any Injury or other trau once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State Aug. Beltsville, MD 2010 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crem. 22. Name and Address of Facility CAFA/Stephen D.Lohrmann P.A. 21. Signature of Funeral Service Licensee MO1585 Melber 8717 Green Pastures Dr. Balto, MD 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final & CYANOTIC CONGENTAL HEART DISEASE - PUMONANY 4 DAYS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): ATTIESIA WITH INDICT VEUMWLAN SEATUM & PDA Examiner TO PULMONARY ANTERY DULING Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) CALDIAC ON THETEMIZATION death certificate be executed Exami physician and s the burial-trans Due to (or as a consequence of): ENTERNON PROBLE BY MEDICAL Box 68760. Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) in the past 12 months? Month Pregnant at time of death ed by the a detached f P.0. 9 Unknown 9 Unknows 23e. Did tobacco use contribute to the cause of death? signed t I be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 3 3 Probably 4 Unknown 2 No 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐Yes 2 ☐No certificate 1 □Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No Certification: To this 28b. Time of Injury Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending death. 1 Yes COMPLIATION OF CARDIAL CATHERIZE 2 Accident 3 ☐ Suicide 300 investigation al or Attends after death 2010 filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 22 S. GREEVE ST BALMONE, MD HOSPINAL To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c, License number 29b. Signature and title of certifier MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DALLMAN 22 S. GREEUE ST BAUMONE, MD 31. Date filed (Month, Day, State Registrar

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